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ABSTRACT

This document presents a transcript of a hearing on the problems of the black elderly poor. Statements read by nine advocates for the aged and agency representatives are included. Among the issues discussed are cutbacks of Federal income support and maintenance programs, housing, health care, and nutrition; and the fact that older blacks are three times more likely to be considered poor than older whites. Four appendices are included: (1) statistics on poverty among aged blacks in 1984; (2) a statement of the American Association of Retired Persons; (3) national policy recommendations generated at the 1985 convention of the National Caucus and Center on Black Aged, Inc., including the increase of Supplemental Security Income (SSI) to above poverty levels; and (4) a statistical profile of elderly black Americans. (KH)

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THE BLACK ELDERLY IN POVERTY

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HEARING

BEFORE THE

CONGRESSIONAL BLACK CAUCUS,
"BRAIN TRUST ON AGING"

AND THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

SEPTEMBER 27, 1985

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THE BLACK ELDERLY IN POVERTY

FRIDAY, SEPTEMBER 27, 1985

House of Representatives,
Select Committee on Aging,
In Conjunction With
the Congressional Black Caucus,
Brain Trust on Aging,
Washington, DC.

The Select Committee on Aging and the Congressional Black Caucus met, pursuant to notice, at 10 a.m., in room 2212, Rayburn House Office Building, Hon. Harold E. Ford (acting chairman of the committee) presiding.

Members present: Representatives Ford and Vento.

Staff present: Roger Thomas, general counsel; Christinia Mendosa, professional staff; Judith Lee, executive assistant; Diana Jones, staff assistant; Carolyn Griffith, staff assistant; and Esther Urbano, staff assistant; of the Select Committee on Aging.

Robert Boyd, administrative assistant; John Murdock, legislative assistant; and Myron Lowery, press secretary; of Mr. Ford's congressional staff.

OPENING STATEMENT OF CHAIRMAN HAROLD E. FORD

Mr. Ford. The Select Committee on Aging will come to order.

First, I would like to thank all of the participants for being with us today as witnesses before the full Committee on Aging. I know due to the weather even the chairman of the committee has had problems this morning in trying to leave early and get some kids to school and trying to do some things to get here before the session today. I do want to thank all the participants and the panelists.

I would also like to take this opportunity to thank the members of my staff as well as the members of the staff of the Select Committee on Aging whose hard work and diligence have made this hearing possible. In particular, I would like to recognize my press secretary, Myron Lowery and Bill McCarthy, of the Social Security Administration who has been assigned to my office under a special fellows program. Their assistance was invaluable in both the coordination and organization of today's hearing.

If I could get the staff now to bring the panelists to the witness tables, I would appreciate it.

Mr. Robert White, National Alliance of Postal & Federal Employees.

Dr. Joyce Berry, Administration on Aging.

Dr. Arthur Flemming, chairman of the Citizens Commission on Civil Rights.

Mr. Jack Ossofky, executive director of the National Council on the Aging.

Dr. Aaron Henry, chairman, National Caucus & Center on the Black Aged, Inc.

Ms. Frances Humphries, National Gray Panthers.

Dr. Ronald Pollack, executive director of the Villers Foundation.

Dr. Sam Simmons, executive director of the National Caucus & Center on the Black Aged, Inc.

Mrs. Shirley Bagley, National Institute on Aging.

Would you come to the panel, please?

Obviously a number of the panelists have not arrived yet due to the weather. When they arrive, we will bring them immediately to the panel.

This morning's Black Caucus Braintrust on the Black Elderly is being cosponsored by the Select Committee on Aging, and I would like to take this opportunity to thank the Select Committee staff and my own staff for the fine job they did in assembling such an outstanding group of distinguished panelists—the names that I have called—and we look forward to a straightforward, simple and rather informal procedure of today's symposium.

Each panelist will speak for approximately 5 minutes, and after all speakers on a particular subject are finished, they will respond to questions and entertain observations of other panelists, and the audience. This is the format we have used in the past and with the cooperation of all of you who are participants today I am certain that we will be able to move right through the agenda this morning.

I would like to just highlight a few things from the congressional perspective, and also talk about a few things which we have witnessed here in the Congress from this administration.

The Reagan administration is waging an undeclared war not on poverty but on the poor, the disabled, and the aged in this country. The Reagan administration we are told has constructed a safety net to protect the least of those among us, and he has talked about protecting the poor of this Nation. The problem is that the net can only catch and protect the very largest fish. We have problems when we see the poorest of the poor who are slipping beyond and in between those so-called safety nets that the President promised the poor of this Nation.

Since Mr. Reagan has taken office hunger has grown, Medicaid support has been reduced, Social Security has been attacked, and the poor among us have increased, the homeless have become commonplace, educational support has been suspect and civil rights passe.

Ronald Reagan has raised his voice in a righteous way, but I say to you Ronald Reagan has not supported any legislation in the Congress that would help the poor or the elderly of this Nation.

And when we think in terms of the 1984, 1985, and 1986 budget proposals and those budgets which have already been adopted by the Congress, we see that this administration more than any other administration in the past two decades has offered and been able to win support for cuts in social welfare programs; cuts in Medicaid, cuts in the Food Stamp Program, cuts in the Medicare Program, and cuts in almost every human needs program. Knowing that we will go into fiscal year 1986 in a very few days from now, this administration has seen fit to offer in every fashion and in every way legislation to continue to send pain and suffering to the elderly of this Nation.

Since Mr. Reagan took office uncompensated hospital care has increased, while Medicaid and Medicare coverage has decreased. The Employee Benefit Research Institute has reported cutbacks in Medicaid eligibility at the State level and noted Medicare's continued refusal, until recently forced by Congress, to pay its fair share of the cost of indigent care. Since 1978, uncompensated hospital care has risen at an annual rate of 10.2 percent to $6.2 billion in 1982. In 1975, the average qualifying level of income for Medicaid was 67 percent of the poverty standard; by 1984, it had eroded to 45 percent of the poverty standard. In 1981, a cap was placed on the amount of Federal support for meals for the elderly provided by and under the Older Americans Act. The number of meals actually provided has declined, and will continue to do so unless Congress is able to offer some legislation and win the support of this body.

Between 1960 and 1969 there was a dramatic reduction in poverty from 22 percent of the population to 12 percent. From 1969 to 1978 the poverty rate remained steady at 11 or 12 percent. Since 1979, however, the poverty rate has increased by 25 percent. Poverty is now up over 15 percent. We have seen the Census Bureau's report. We have been privy to the report that was released by the physicians task force headed by Dr. Larry Brown of Harvard that showed us that some 20 million Americans in this Nation go hungry two to three days every month. We are talking about children. We are talking about the aged. We are talking about Americans.

Mr. Reagan, after promising to leave Social Security benefits alone while running for office, promptly offered legislation that would interfere with and delay your COLA and other beneficial provisions of the Social Security Act. What has this done to the elderly? I need not say. The point has been made by Mr. Reagan's action much more strongly than I could make here today. Mr. Reagan is pro Mr. Big and anti Mr. Little, he is for the defense of the privileged few of this country, as we can see from his actions.

My point is quite simple. It is this: No one in this prosperous country should be forced by economic conditions to go hungry or homeless or lack adequate health care. Yes, we have a financial problem in this Nation. Yes, we are working under budget restraints in this Congress. We need a better balanced budget; but a budget that makes the poor poorer makes us all poorer. A Government whose policies increase the gap between the "haves" and the "have nots" must be changed. A Government that abandons the elderly, its sick, its unemployed, and its homeless must be changed. A President who reneges on promises to the aged and the poverty-stricken loses all honor. A Congress that would barter away health care and education, the vitality of its cities, and the income of its aged in the name of defense is saying that we do not care about the poor in this Nation.

Today, you people, you experts in the problems of the elderly have gathered to share information with this braintrust to the Congressional Black Caucus on the aged. I look forward to receiving this information. The Select Committee on Aging looks forward to receiving this information. Our working together hopefully will bring about needed changes for the poor.

I welcome you to join the Select Committee on Aging as well as the Congressional Black Caucus today in offering your testimony and your comments.

At this time the Chair will recognize the first—well, I can't say the first panelist because I don't see Mr. White in the audience yet. We will pass by the "Housing Services" by Mr. Robert White.

Is Dr. Aaron Henry here? Dr. Henry is not here?

Mr. Ossofsky, the executive director of the National Council on the Aging, who will be speaking to us today, addressing us on "Income Maintenance for the Elderly."

Is Dr. Flemming here yet? He is not.

Well, we will go right ahead, Mr. Ossofsky. We will hear your testimony at this time.

STATEMENT OF JACK OSSOFSKY, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON THE AGING

Mr. OSSOFSKY. Thank you, Mr. Chairman. I appreciate very much the opportunity to be here today, and want to particularly at the outset extend to you the greetings of our president, Dr. Anna Brown, who, but for her illness, would be with us here today.

This hearing serves a particularly important function in highlighting the continuing needs of a very significant and large segment of America's aged, the black elderly, and poverty. It comes at a time when we hear, as you have outlined, a great deal, particularly from this administration and those allied with it, that we have completed the national agenda on behalf of the aging, that they are doing well—indeed, better than other segments of our society—and it is time to turn our attention to other vulnerable populations.

We do not deny for a moment the gains over the last five decades on behalf of most older Americans. That is our victory. We rejoice in improved circumstances for which we and others advocated and which you and others made possible through the enactment of legislation that provided improved income, health care, housing, social services, and a myriad of other programs. But our agenda is far from complete. Nor is our progress uniform across the spectrum of the aged. You are correct in singling out the needs of the black elderly poor for special attention. While their circumstances, too, have improved in recent years, that improvement documents the disparity of progress we have achieved and how inadequate that progress is.

From 1969 to 1983 the percent of aged whites living below the poverty line dropped from 23.3 to 12 percent, while poverty among older blacks decreased during this same period from 50.2 to 36.3 percent. Yes, there is progress in both sets of figures, but we still end up with three times the level of poverty among older blacks.

There are those who would have us believe that a rising tide raises all ships. These figures indicate that without special targeted efforts that tide swirls past those mired at the bottom by a lifetime of discrimination, low-paying jobs, high unemployment, late coverage by and therefore low Social Security benefits, less access to private pensions, and all other circumstances that shape the lives of today's older blacks as they grew up and grew old but in large measure stayed poor.

My testimony which is before the committee and which I ask that it be entered in the record in totality——

Mr. **Ford**. Your full statement will be made a part of the record.

Mr. **Ossofsky**. Thank you, Mr. Chairman—provides the statistical backup for the statement I have just made. Particularly, I would like to underscore that not only are blacks in general at a lower state in the economy, but black women in particular, whether living alone or with families, are among the poorest of the Nation's poor. In all, 41 percent of older black women remain living below the poverty line of our country. And even if we were to move up just a bit to those living within 125 percent of the publicly defined poverty level, almost half—44.8 percent—of all black older persons remained with incomes within that category.

Let me underscore that statistics sometimes make us forget that we are not talking about numbers, Mr. Chairman, we are talking about people. In 1983, there were 2,226,000 blacks aged 65 and older: 1,345,000 women, some 882,000 men. We are talking here not about cold, simple numbers; we are talking about live, living people in poverty.

With these levels of income the significance of public supported programs for income, health, housing, and social services for the aged, especially the black aged, become clear. Indeed, such progress as was made by all older Americans can largely be attributed to the enactment of income improvements and other services during the period 1960 and 1974. We are continually told these days that the marketplace will take care of the needs of the aged. Mr. Chairman, this born again Horatio Alger has nothing to do with fact. The reality is that we made progress because the Congress responded to needs, and the Federal leadership led in that effort.

In the last 50 years we patterned a national direction of social progress. In the last 4½ years what we have is curtailment and cuts. It is important to recognize, in particular, the significance of improved Social Security and the enactment of the COLA amendments in the progress made on behalf of the aged, and to underscore therefore the importance of the victory achieved during the recent budget battle in defending the continued existence of the COLA.

Precisely, the poorest of the aged, older blacks, need the assurance by the Congress that the COLA will not be undermined now or in the future. It is not negotiable. It is a lifeline that cannot be cut. It is urgent, however, to remember that those whose floor of benefits remain low need continued increases in Social Security, and especially in SSI.

What we would recommend, Mr. Chairman, as a priority issue therefore in improving the levels of income of older blacks and other poor people is to elevate the level of minimum benefits of SSI above the threshold of the Government's poverty index. In that way we can eliminate poverty among the aged once and for all.

You know, Mr. Chairman, the history of the last 50 years shows, and particularly since the years of the development of Medicare, Medicaid, and the other benefit programs, that we recognized that there was a problem in the 1960's and 1970's and a strange thing happened: we threw money at the problem and it helped solve the problem. We improved Social Security benefits, we provided SSI, and we made some element of progress.

If we are to make the progress needed on behalf of older poor blacks in our country, we need to invest in that solution. It cannot be done in any other way.

One of the aspects of our progress is that more older blacks are indeed living longer. Yet at this very time when there are improvements in longevity among minorities of our country, the compromise of 1983 to secure the Social Security package caused us to include in it a delay in the ages at which workers retire. The ages at which workers should be able to draw full or early benefits under Social Security should remain where they are, Mr. Chairman. Sound social policy demands that we provide positive incentives to encourage a longer worklife, but not penalize those who are ill or whose work is physically demanding, onerous or dangerous and, therefore, who may choose to retire early or at age 65.

Now that longevity is within the grasp of America's black population let us not push off their chance to benefit from their contributions and from the respite that they could receive from the nature of the work that has characterized too many of their lives. Let us change the Social Security law back to the place where it belongs, with age 65 the option for retirement and earlier retirement for those who want it and need it.

This committee, too, needs to examine carefully in protection of the incomes, SSI and health care of America's older poor. The plans of the Social Security Administration to close down over 772 of its 1,340 offices in rural areas as well as the consolidation of its urban neighborhood offices in spite of statements made by Secretary Heckler and Acting Social Security Commissioner McSteen that no such action was contemplated, 15 of the vulnerable offices have already been closed. In addition, the administration is proposing to reduce Social Security staff by 21 percent over the next 5 years. In the name of cost curtailment, Social Security accessibility to the frail, the poor in rural areas and urban ghettoes and barrios, will be reduced if these plans proceed. This must not be permitted to happen to the agency that deals with Social Security, Medicare and SSI—the critical income and health programs for the aged poor.

My testimony, Mr. Chairman, provides a series of significant recommendations I believe on protecting the health security of older poor blacks in particular. Because of the press of time I will concentrate on the income issues, but do recommend to the committee a careful examination of these recommendations.

Ultimately, we need not a tinkering with the health care system, Mr. Chairman, we need a complete redo of the system and the beginning of steps that provide adequate health care for Americans of all ages. Our documentation in the testimony points out that in our studies and studies we have commissioned by Louis Harris, and more recent ones undertaken by the National Citizens Board of Inquiry Into Health in America, that the needs of older blacks in particular continue to be unserved adequately by the Medicare system.

The cost of doctor bills, the cost of participating in the system, the coinsurance payments, the premiums, present a burden in addition to the accessibility of health care. This must once and for all be resolved.

We will, however, cure no illness and help no patient by simply cutting Medicare benefits and Medicaid benefits. What we do is add to the burdens of the poor and the sick in the current administration recommendations.

Mr. Chairman, our organization is particularly concerned about the aged, but it must be underscored that we are concerned about today's and tomorrow's older Americans. In this context, it is very important for all of us to reject the intergenerational wars being proclaimed in some quarters and that seek to limit the progress we make on behalf of older people.

We are advocates for jobs, training and opportunities for today's young and middle-aged or tomorrow's old. The continuing enormity of young black unemployment is not only a tragedy for today, Mr. Chairman, it relates to the issues of today's hearing for it carries with it the seed of the coming generations of tomorrow's older poor. Tomorrow's older black poor are sitting on the stoops of our major cities in the bodies of today's young black poor. This pattern must be broken. That future must not unfold.

Likewise, the continuing trade and economic policies of this administration are costing us jobs and creating unemployment particularly for newly skilled black industrial workers who have finally gotten seniority, pension and health coverage. They are increasingly today to be found among the displaced and discouraged young and middle-aged workers, out of jobs and out of future retirement protection. Increasingly our economic and trade policies almost be seen as impacting on jobs of a newly emerging, mature and middle-aged group of workers who for the first time include significant numbers of blacks. Without massive intervention, they, too, are likely to be among the next cohort of the older poor.

Our income support programs, our training programs, our employment programs therefore must cut across all generations. An aggressive stance on behalf of continued social progress for all generations is needed to assure a more secure and healthier old age especially for those still burdened by a lifetime of patterns of racism and discrimination.

In the last 5 years we have been told we have problems as a nation with diminished resources and must cut back our investment in human services. I do not accept that notion for one moment, and I urge the Congress to reject it vigorously. Our resources are not diminished; our priorities are perverted. Let us invest in programs to enhance life, not in instruments of death, and we will have the resources to solve the Nation's problems.

Churchill pointed out some years ago that to govern is to choose. Not just between political constituencies, but choices between human outcomes. It was such choices that we as a Nation made to use our common strength through government to weave a network of programs to protect one another against the vicissitudes of life; especially a long life, which increasing numbers of our fellow Americans are achieving. Those efforts have enabled millions to look forward to those added years with a measure of security. But millions more, particularly older blacks, members of other minority groups, and millions of older women, have yet to share in our progress. Their tomorrow, Mr. Chairman, is now. We can wait no longer, nor should we. Let us act, Mr. Chairman. Let us act now.

Thank you.

Mr. **Ford**. Thank you very much. An excellent presentation, and we want to thank you very much.

[The prepared statement of Mr. Ossofsky follows:]

PREPARED STATEMENT OF JACK OSSOFSKY, EXECUTIVE DIRECTOR, THE NATIONAL COUNCIL ON THE AGING, INC., WASHINGTON, DC

Mr. Chairman, Members of the Committee, thank you for inviting the National Council on the Aging to join in today's hearing. As the Council's Executive Director, I am pleased to present our organization's views. May I at the outset extend to you the greetings of our President, Dr. Anna v. Brown, who, but for an illness would be here today.

This hearing serves a particularly important function in highlighting the continuing needs of a significant and large segment of America's aged: the black elderly in poverty. It comes at a time when we hear a great deal, particularly from the Administration and those allied with it, that we have completed the national agenda on behalf of the aging, that "they" are doing well, indeed better than other segments of society and that it's time to turn our attention to other more vulnerable populations.

We do not deny the gains made in the last five decades on behalf of most older Americans. They are our victory. We rejoice in the improved circumstance for which we and others advocated and which you and others made possible through the enactment of legislation that provided improved income, health care, housing, social services and a myriad of other programs. But our agenda is far from complete nor is our progress uniform across the spectrum of the aged.

You are correct in singling out the special needs of the black elderly poor for special attention. While their circumstances, too, have improved in recent years, that improvement documents the desparity of progress we have achieved.

From 1969 to 1983 the percent of aged whites living below the poverty line dropped from 23.3 percent to 12 percent, while poverty among older blacks decreased during this same period from 50.2 percent to 36.3 percent. Yes, there's progress in both sets of figures, but, we end up with three times the level of poverty among older blacks.

There are those who would have us believe that a rising tide raises all ships. These figures indicate that without special targeted efforts that tide swirls past those mired at the bottom by a lifetime of discrimination, low paying jobs, high unemployment, late coverage by and therefore lower social security benefits, less access to private pensions and all the other circumstances that shaped the lives of today's older blacks as they grew up and grew old—but in large measure stayed poor.

And, if you separate out the aged poor by sex and living condition, that is whether living in families or alone or with unrelated individuals, in every circumstance older blacks, and especially older black women, are more apt to be still found among those living below the poverty level:

White males: 6.1 percent in families, 18.5 percent alone, total 28.3 percent.
White females: 7.0 percent in families, 24.5 percent alone, total 14.7 percent.
All White poor: 6.6 percent in families, 23.3 percent alone, total 12.0 percent.
Black males: 21.9 percent in families, 45.0 percent alone, total 28.3 percent.
Black females: 26.4 percent in families, 63.4 percent alone, total 41.7 percent.
All Black poor: 24.3 percent in families, 58.4 percent alone, total 36.3 percent.

Almost half (44.8 percent) of all black older persons had incomes in 1983 below 125 percent of the publicly defined poverty level.

In 1983, the median income of older blacks remained just a bit over half that of other whites and as age went up, income of both went down. This was especially so for older black women.

The median income for white males age 65–69: $12,180.
The median income for black males age 65–69: $7,097.
The median income for white males age 70 and older: $9,109.
The median income for black males age 70 and older: $5,114.

Again it is important to underscore that these income levels were what great numbers of individuals lived on as recently as 1983. In that year there were 2,226,000 blacks age 65 and older (1,345,000 women, 882,000 men) and 24,772,000 whites, aged 65 and older (14,837,000 women and 9,933,000 men).

With these levels of income, the significance of publicly supported programs for income, health, housing and social services for the aged, especially the black aged become clear. Indeed, such progress as was made on behalf of all older Americans can largely be attributed to the enactment of income improvements and other services during the period 1960–1974.

During this period Social Security benefits began their rise, private pensions were installed, and, most important, cost of living increases were enacted as part of Social Security. From 1968 through 1971 benefits rose by 43 percent and the 1972 amendments increased them further by another 20 percent.

The result was that poverty for the aged as a whole dropped from 28.5 percent in 1966 to 14.6 percent in 1974. A peculiar thing happened. We saw a problem, threw money at it and the money began to reduce the problem.

It is important to recognize the significance of improved Social Security and the enactment of the COLA amendments in the progress made on behalf of the aged and to underscore, therefore, the importance of the victory achieved during the recent budget battle in defending the continued existence of the COLA.

Precisely the poorest of the aged, older blacks, need the assurance that the COLA will not be undermined now or in the future. It is not negotiable. It is a lifeline that can not be cut.

It is urgent, however, to remember that for those whose floor of benefits remains low continued benefit increases in Social Security, and especially in Supplemental Security Income (S.S.I.) are needed to move the lower benefits to a point above the poverty line and thereby to eliminate poverty among the aged once and for all.

One aspect of our progress is the sign that increasing numbers of blacks are living longer, especially black women. Not only are there more blacks surviving to and past age 65, but more are reaching 75 and older, again this is particularly true among women.

In 1984, 91 percent of the aged were white, while 9 percent were non-whites though 85 percent of the total population was white and 15 percent non-white. In the next century significant changes in the proporation of non-white aged are expected. By the year 2025 15 percent of those over 65 are expected to be non-whites and by 2050 19 percent of the aged will be non-whites.

Yet, at the very time that more blacks, hispanics and other non-white will be extending their lifespan, the age of eligibility for retirement benefits will be raised. Enacted as part of the Social Security compromise of 1983, at a time of concern for the fiscal security of the program, this issue should be reconsidered now that the system is again secure and projecting a major surplus.

The ages at which workers should be able to draw full or early benefits under Social Security should remain where they are. Sound social policy demands that we increase options for the aged, not remove them. Sound social policy demands that we provide positive incentives for encouraging a longer work life, but not penalize those who are ill or those who work is physically demanding, or onorous or dangerous and who, therefore, choose to retire early or at age 65. This must be an issue of special concern to this committee and other advocates for and with older blacks, disproportionately fewer of whom have lived long enough to retire in the past. Now that greater longevity is finally within their grasp, let us not push off their chance to benefit from their contributions and from respite from the nature of the work that has characterized too many of their lives.

This committee needs, too, to examine carefully the plans being put into effect by the Social Security Administration to close down over 772 of its 1340 offices in rural areas as well as to consolidate its urban neighborhood offices. In spite of statements by Secretary Heckler and Acting Social Security Commissioner McSteen that no such action was contemplated, 15 of the known "vulnerable" offices have already been closed. In addition, the Administration is proposing to reduce Social Security staff by 21 percent over the next five years. In the name of cost curtailment, Social Security accessibility to the frail and the poor in rural areas, in urban ghettos and barrios will be reduced if these plans proceed. That must not be permitted to happen to the agency that deals with Social Security, Medicare and SSI, the critical income and health programs for the poor aged.

In preparation for the 1981 White House Conference on Aging, NCOA commissioned Louis Harris and Associates to undertake a massive poll of the perceptions and realities of aging in America. Most of its findings continue to be reinforced by later studies, and some have particular relevance to this hearing.

For example, while most older people reported that they believe that older Americans are healthier than 10 years earlier, this was not the case with older blacks. Forty-nine percent of the older blacks disagreed that the health status of the aged had improved. Fully, 63 percent of elderly blacks assessed their own health as "only fair" or "poor," Only 36 percent of older blacks described their own health as excellent or good compared to 59 percent of older whites. In related questions dealing with availability, cost and access to health care, older blacks, particular older low income blacks reflected more concern and described more problems. As just one example from the report, while less than 1 in five elderly whites (19 percent) viewed having inadequate medical attention as a very or somewhat serious problem for themselves, more than one-third of elderly blacks 34 percent felt that it was a somewhat or serious problem.

While nearly all Americans of all ages (87 percent) reported feeling that Medicare should cover more health care services provided at home, support for such service expansion was greatest among blacks (95 percent) who are clearly reflecting their concern about their health and that of their older relatives and the inadequacies of resources to deal with health.

While elderly blacks, like most other older persons, reported using private physicians for most of their health care, they were, however, significantly more apt to use outpatient clinics. Almost one-fourth (21 percent) of the older black respondents report getting their health care this way compared to only 6 percent of older whites.

In spite of the existence of Medicare, older blacks continued in significant numbers to put off doctor visits, due to the cost, when they felt something about their health warranted such a visit. While one out of 7 older persons (14 percent) reported such delays, 21 percent of those with annual incomes under $5,000 and 19 percent of older blacks reported such delays.

Expense of doctor care is the top reason (39 percent) cited by the aged for not seeing a doctor.

Permit me to underscore, Mr. Chairman, that this study was undertaken in 1981, prior to the vast cuts and program consolidations undertaken since by this Administration, often with the support of a too compliant Congress. Out of pocket costs to beneficiaries of Medicare have risen, monthly Part B premiums have gone up and the eligibility standards for Medicaid have risen. The poor, especially the older poor need health care coverage not health care cuts.

Furthermore, the disparity of eligibility standards, benefits and services available in different states serves to penalize the poor because of where they live. We must move forward with an agenda that assures health care for all Americans, especially the poor. As steps in that direction, the Congress should require uniform standards and minimum services to be made available in every state under Medicaid, improve the Medicard program, remove barriers to its use and increase its benefits to those who must rely on its provisions for their health. Among the greatest beneficiaries of such steps would be older poor blacks.

In its Public Agenda, The National Council on the Aging therefore recommends action by the Congress to assure that the states:

Remove limitations on the amount, duration or scope of medical services that were imposed to save money rather than to meet the health needs of the medically indigent.

Reject imposition of copayments that restrict eligibility and increase burdens for the poor of all ages.

Refuse to require families of patients in nursing homes to pay part of the charges under Medicaid because such efforts are unworkable and unfair to individual family members who may already have borne much of the brunt of caregiving before institutionalization became necessary.

Reject proposals to reduce the Federal share of Medicaid and seek restoration of the original Federal share.

Provide mandated services to all persons whose incomes are below 125 percent of the poverty line.

Offer additional services important to individuals that prevent or lessen the pain and suffering of ill health.

Explore ways to reduce institutional costs by making noninstitutional care more available and provide community-based, responsive care and support alternatives for older persons. The capacity of senior centers and adult day care programs to provide a holistic approach to individuals should receive special attention.

The Congress can and must see to it that these steps are taken.

The NCOA Harris poll and a more recent report of a series of local hearings by the National Board of Inquiry Into Health In America, which we published, underscore the continued vulnerability of older poor blacks due to poor health care. Our health delivery system in spite of the major improvements resulting from Medicare's enactment remains deficient and unresponsive to the special needs of older blacks and others.

There is significant and growing evidence that older black experience especially harsh access problems which, combined with the mounting cost of health care and the lack of coverage for needed services, contribute to deterioration of their health.

The National Health Law Project reported recently that primary care providers are "virtually non-existent" for nearly 20 million people living in rural areas and deteriorating neighborhoods. High in their numbers are older poor blacks.

Twenty years after its enactment Medicare has become a new center of debate; a debate that overlooks why it was established and examines only its current costs. In fact, Medicare's fiscal problems reflect, but are not the cause of, the fundamental flaws in our nation's health care system. Its patients and beneficiaries are not the cause, but the victims of a deficient, fragmented health delivery system.

Rather than overprotecting the aged, Medicare today requires its participants to: Pay as high a proportion of their incomes for health care as they did before the law was enacted; cope with increased payments and deductibles in order to receive coverage; and pay, themselves, for significant health costs ranging from out-of-hospital drugs and appliances to nursing home stays.

The recently included programs of DRGs is producing some lower costs but we are receiving increased evidence that it is also producing more patients being dumped out of hospitals. Even the nursing homes are complaining. We need to reduce the cost, not the care.

The time has come to stop coping with the need for a careful systematic overhaul of our health care delivery machine through cost-curbing mechanisms and reductions in benefits. Cost-sharing, prospective payment plans, higher deductibles will not add quality, will not provide cures or prevention. They divert us from the real issues and add to our burdens.

It will cure no illness to accept further cuts in Medicare and in Medicaid. Neither will it solve the problems of our health care system. What it will do is add to the burdens of those already sick. Our unfinished agenda includes the building of a system that is more responsive and effective than what we presently have, so that:

It provides real long-term care options in comprehensive coordinated community-based services as well as institutions;

It provides protection against catastrophic illness;

It offers greater response to the mental health needs of older Americans;

The burdensome cost of drugs and medical appliances are covered;

The poor are adequately protected through the integration of Medicaid; and

Health is promoted throughout the lifespan.

NCOA's Public Policy Agenda states:

"Medicare, the central element in health care for older Americans, needs major reform. But current plans aimed at cost-shifting and cost containment do not aim at reform. They promise little more than heavier burdens on those most in need of help. Copayments, for example, are a direct charge on those unfortunate enough to fall ill; increased copayments would be particularly onerous on low-income Medicare participants, who pay a greater proportion of their income for copayments than those with higher incomes."

Therefore, NCOA recommends that the Congress:

Resist new attempts to increase copayments and deductibles under the hospital and medical parts and premiums under its medical part.

Refuse to impose a means test on Medicare recipients.

Reject proposals to establish a voucher system to supplement Medicare as unrealistic on several grounds: (1) "shopping" for health insurance in the private market would be difficult for many older Americans; (2) elders who opt to remain in Medicare would probably be those most in need of treatment; (3) Medicare's base of support would be diminished at a time when it should be broadened.

Insist that congressional intent be heeded in implementation of Medicare reimbursement for hospice services; the hospice goal of providing "support and care for persons in the last phases of disease so that they can live as fully and comfortably as possible" should be fully met.

Freeze physician fee levels and require physicians to accept Medicare's assigned fee levels for at least two years.

Expand Medicare coverage to include comprehensive in-home and day care services, health maintenance services, hearing aids, eyeglasses, most prescription drugs, food care and most dental work.

Provide incentives for states to establish statewide health care plans, under Federal guidelines, to meet national cost reduction standards while meeting individual state needs and priorities.

Investigate the reasons for very limited enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and increase Federal support for development of HMOs. In addition, Congress should closely scrutinize findings from a forthcoming study of the potential of Social Health Maintenance Organizations (SHMOs), which are intended to provide a complete range of social and health services, following HMO principles. If SHMOs' findings are encouraging, Medicare coverage should be considered at an early date in the interest of cost effectiveness and increased support for genuinely comprehensive community-based care/support systems.

Design a catastrophic hospital coverage feature under Medicare that would not be a trade-off with cost-sharing requirement made on all persons who receive hospital benefits under that program. Catastrophic coverage should be considered on its own merits and not as a part of a package deal.

Make help (including in-home services, respite and tax deductions) available to families attempting to provide support for older family members.

Mr. Chairman, I have touched on but a few of the many problems that confront the older black poor of America and all of us who must act to change the circumstances they face. I have on behalf of The National Council on the Aging proposed some of the things this Congress can, and indeed, must do if this pattern of poverty and discrimination for the aged black is to change. But, there is much more on our agenda, and I will be happy to submit our other comprehensive recommendations to you. I have concentrated on these issues of income and health security as a priority, not a totality of needed action.

May I underscore to you, Mr. Chairman, and the members of this committee, that as our organization focuses its major efforts in the field of aging, we are concerned with both today's and tomorrow's old. In that context, we reject the integenerational wars being proclaimed in some quarters and undertake programs that bind the generations. We also are advocates for jobs, training and opportunity for today's young and middle-aged. The continuing enormity of young black unemployment is not only a tragedy for today. It carries with it the seed of the coming generations of tomorrow's older poor. Tomorrow's older black poor are sitting on the stoops of our major cities in the bodies of today's young black poor. That pattern must be broken. That future must not unfold.

Likewise, the continuing trade and economic policies of this Administration are costing us jobs and creating unemployment particularly for newly skilled black industrial workers who had finally gotten seniority, pension and health coverage. Today, they are increasingly being found among the displaced and discouraged young and middle-aged workers out of jobs and out of future retirement protection.

Increasingly, our economic and trade policies must be seen as impacting on jobs of a newly emerging mature and middle-aged group of workers who include for the first time significant numbers of blacks. Without massive intervention, they are likely to be among the next cohort of the older poor.

Hence, an aggressive stance on behalf of continued social progress for all generations is needed to assure a more secure and healthier old age, especially for those still burdoned by the patterns of racism and discimination.

Time and again in the last five years we have been told that we have problems and are faced with diminished resources and must cut back our investments in human services. I do not accept that notion for one moment. Our resources are not diminished. Our priorities are perverted. Let us invest in programs to enhance life, not in instruments of death, and we will have the resources.

Churchill pointed out some years ago that to govern is to choose. Not just choices between political constituencies, but choices between human outcomes.

It was such choices that we as a nation made to use our common strength through government to weave a network of programs through which we could protect one another against the vicissitudes of life—especially a long life, which increasing numbers of our fellow Americans are achieving. Those efforts have enabled millions of older Americans to look forward to those added years with a measure of security. But, millions more, particularly older blacks, members of other minority groups and millions of older women have yet to share in that progress.

Their tomorrow is now, they can wait no longer, nor should we. Let's act Mr. Chairman, let's act now.

Mr. **Ford**. Before I recognize Dr. Flemming, I would like to give some thought to one of the statements you made about supplemental security income and the poverty threshold. Knowing that there are only 4 million people who receive supplemental security benefits, and many more who are receiving Social Security what would you do about those who are not eligible for supplemental security benefits and but receive Social Security benefits and do not meet the poverty threshold? Perhaps when we open the discussion to the audience we can gain some insight as to how this issue might be addressed by the Congress.

Right now I think for a single individual the poverty threshold is about $5,800 or $5,900. I would like to know, if we raise the supplemental security income threshold to $5,800 a year, what would we do about Social Security? How many people who receive Social Security would remain below the poverty level. This problem should be addressed not only for the black elderly, but for all the elderly who are living below the poverty level.

Dr. Flemming, we are very delighted to have you with us today. We look forward in hearing from you. We will recognize you at this time. But before I recognize you I would like to say that Chairman Roybal is not here with us today. He apologizes for not being here. He does have a statement that he would like to make a part of the record.

At this time I am going to ask that his statement be made a part of the record, and get staff to give it to the clerk.

[The prepared statement of Chairman Edward R. Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

I want to commend the Congressional Black Caucus in convening, under the auspicies of the House Select Committee on Aging, a most important hearing on "The Black Elderly in Poverty," a subject which receives too little attention in our present political climate. While it is the purpose of this hearing to examine the specific problems associated with being black, old and in poverty in this Nation, what we are examining, in part, is this society's commitment and concern for it's older special populations. This society's desire to be equitable and just in the dissemination of those resources needed by the black elderly, a group that has contributed much to the success of this Nation. This legislative workshop hearing will examine ways in which we can better serve the special needs of special people, the black elderly in poverty.

I want to express my deep appreciation to Congressman Harold Ford, a senior member of the select committee, for his support of the work of the Committee on Aging and especially for his effort in bringing together this distinguished group of academicians, legislators, and experts in the fields of health, social services, income maintenance and other fields of endeavor which provide essential services to our Nation's elderly.

When we think about the plight of our elderly, we must keep in mind that there is still an unfinished agenda to address the special needs of the black elderly. We should continue to be concerned that our elderly, in all too many instances, lack adequate health and hospitalization care and the bare essentials of adequate nutrition, affordable housing and transportation services and adequate income maintenance services such as Social Security and private pensions.

We know that the effects of Medicare and, Medicaid benefit cuts, together with health care cost inflation, have greatly increased the already excessive financial burden carried by many elderly persons. The black elderly in poverty find it almost impossible to stretch their limited incomes to cover these essential needs.

These desparaties are not isolated, but cover the spectrum of human needs and social services. The black elderly in poverty are, in too many instances, not receiving the benefit of Governmental programs targeted to help the economically disadvantaged. For example, roughly 75 percent of the male population aged 65–85 participate in the Medicare Program, while only 2 percent of that same population receive Medicaid benefits. Only 67.5 percent of all black women aged 65–85 receive Medicare assistance, while 14.6 percent of all black women of that same age receive Medicaid assistance only. These and similar statistics involving the black elderly continue to demonstrate that more needs to be done through our governmental assistance programs.

I know that members of the Select Committee on Aging are concerned about the issues that you will address today. I look forward to your suggestions and recommendations to assist the committee and Congressman Ford in formulating legislation and other governmental policies that will assist and support the black elderly in poverty.

Mr. FORD. At this time, Dr. Flemming, we will recognize you.

STATEMENT OF ARTHUR FLEMMING, PH.D., CHAIRMAN, CITIZENS COMMISSION ON CIVIL RIGHTS

Dr. FLEMMING. Thank you very much, Mr. Chairman. I certainly appreciate being invited to participate in this hearing on "The Black Elderly in Poverty." I am going to assume that a case has been made which makes it clear that there are millions of our black elderly who are trying to live on incomes which are either below or just above the poverty line. This means that they are called upon to deal with an inadequate welfare system. It also means that they must settle for inadequate housing, health care, food and clothing. The question that confronts us as a Nation is what can and what will we do about it?

It seems to me that we must bring the Federal floor for the Supplemental Security Income Program up to the poverty threshold. At the same time we must work to extend the concept of an income floor to all age groups. We do not want our children and grandchildren to continue to confront the suffering that accompanies poverty.

Also, we must defeat any efforts to break the compact which is the cornerstone of Social Security by reducing benefits under the survivorship, disability or retirement programs. An effort was made to reduce benefits by $22 billion over a period of 3 years for children, widows, disabled under 65, and older persons. This effort revolved around the proposal to freeze the cost-of-living adjustment. This effort was defeated, and as a result, persons were saved these cuts of $22 billion.

But even more important it seems to me, we must keep in mind the fact that if this proposal had passed it would have been the first time in a period of 50 years that the Congress would have reduced benefits just to make the overall budget look better. And in my judgment, if that happens once, every time the Congress faces a crunch as far as the overall budget is concerned they would turn back to the Social Security benefits. And once that is done two or three times the concept of a compact would be completely undermined and the system itself would be in jeopardy.

I personally commend the Members of Congress who stood firm and resisted that effort to cut the benefits. I know those efforts will be renewed, and we must do everything we can to prevent any further cuts in the Social Security benefits.

As the chairman has just indicated, we also confront some issues in terms of adjusting Social Security benefits upward. Then it seems to me we must enact into law programs that will open job opportunities. Certainly older persons have demonstrated that when these opportunities are presented, through the Foster Grandparents Program, the Retired Senior Voluntary Program, Senior

Aid Program, Green Thumb Program, they respond. And when they respond they have demonstrated their ability to render a very unique service to our Nation. These programs should be expanded.

In addition to that we should increase our investment in public service jobs on an overall basis. The bill that Congressman Hawkins has sponsored in the House over a considerable period of time is the kind of legislation that should be enacted.

Likewise, I believe the time has come to enact into law the provisions of the executive order which require Federal Government contractors to development and implement affirmative action plans. We can no longer rely on the Federal Government to continue to keep that executive order in effect and to implement that executive order. Consequently, it seems to me that it is imperative for the Congress to take the basic concept in that order and enact them into law.

Likewise, it seems to me we must take the following steps in the area of health care. We must enact the Kennedy-Gephardt cost containment bill in order to bring health care costs under control. We must merge parts A and B of Medicare into one trust fund. We must provide for increased Medicare benefits that will cover care of eyes, teeth, loss of hearing, prescription drugs, catastrophic illnesses, and more adequate home care. We must amend Medicaid so that persons who are medically indigent will qualify for it without meeting welfare eligibility standards.

Likewise, I believe that we must work for an increase in the resources available under the Older Americans Program that will take into consideration both the rate of inflation and the increase in the population of older persons, including the black elderly. The implementation of such a program and other similar proposals that are pending before the Congress will result in increased appropriations. So it seems to me that we must push for actions that will enable these programs to be implemented within a framework of fiscal responsibility. We must push for tax reform program which will achieve fairness and provide the Federal Government with additional revenue. We must push for a national security program that will be consistent with the following extract from a letter written by the late President Eisenhower in April 1956, when he said:

> I have spent my life in the study of military strength as a deterrent to war and in the character of military armaments necessary to win a war. The study of the first of these questions is still possible, but we are rapidly getting to the point that no war can be won. War implies a contest. When you get to the point that contest is no longer involved and the outlook comes close to destruction of the enemy and suicide for ourselves, an outlook that neither side can ignore, then, arguments as to the exact amount of available strength as compared to somebody else's are no longer the vital issue. When we get to the point, as we one day will, that both sides know that in any outbreak of general hostilities regardless of the element of surprise, destruction will be both reciprocal and complete. Possibly we will have sense enough to meet at the conference table with the understanding that the era of armaments has ended and the human race must conform its action to this truth or die.

We have been engaged in a good many damage control actions. Damage control actions that have been definitely related to the welfare of the black elderly who find themselves confronting poverty. We must continue those damage control actions, but I also feel that the time has come for us to get behind affirmative programs that will not only retain the status quo, but make it possible for us to move forward and move forward in such a way that we, in not 10 years from now or 5 years from now, but in the next few years, move many, many of the elderly persons of this Nation out of poverty. This is the only way in which we can supplant despair with hope in their lives.

Thank you, Mr. Chairman.

Mr. **Ford**. Thank you very much, Dr. Flemming.

The Chair would like to recognize another senior member of the committee, Congressman Vento from Minnesota, at this point.

Mr. **Vento**. Thank you, Mr. Chairman. I want to commend you for the hearings and the distinguished panel which you have assembled to help us understand and explore the problems that elderly Americans, black elderly Americans especially, are experiencing. I hope that this will serve as a catalyst to prompt Congress to address these concerns. I stand ready to work with you. And I commend you again for exploring this issue and bringing it to public attention and to the Congress' attention.

Mr. **Ford**. Thank you very much.

We will open the floor, an open discussion on income maintenance for the elderly. I had put the question out earlier.

And, Dr. Flemming, once again I would like to thank you for your testimony. I know that you have served on the Presidential Commission when we reformed the—so-called reform of the Social Security Administration here in recent years. You also have testified on many occasions before my subcommittee, as well as the full Committee on Ways and Means. We are delighted to have your expertise here with us today.

But I would like to open up our discussion, for the next 10 or 15 minutes, on how we could structure a program that would protect the black elderly and the poorest of the poor.

I would like to open the floor to talk about the COLA, the cost-of-living adjustment, as well as any reform that be needed.

And I would like to say for the record the Subcommittee on Public Assistance as well as the full Committee on Ways and Means, are already considering legislation that would, in fact, increase the SSI payments to the recipients. We know that the administration has indicated, even, in this last budget proposal, that they had no real objection to any increases in SSI. But once we move in that direction we would like to know what should be done to insure that social security beneficaries who are not eligible for SSI and are living below the poverty level, do not stay below the poverty level.

The floor is open. We would like to use the podium to my right, which will be to your left. There was a mike on that podium a minute ago. Is it still there? The mike is there at the podium. Feel free to come to the podium for discussion.

I would like to hear the two members of the panel discuss how can we make adjustments in SSI and not make those same adjustments in Social Security benefits as well.

Dr. Flemming, if you would like to start.

Dr. **Flemming**. I think you have definitely put your finger on a very fundamental issue. We have been observing the 50th anniversary of Social Security, and that has made it necessary, I think, for some of us to go back and take a look at what the objective was back 50 years ago when we got started on our social insurance program. It is very, very clear that objective 50 years was ago to begin the development of a social insurance program that would deal with the hazards and vicissitudes of life. It was clear from the start that everyone wanted to deal with the hazard and vicissitude that confront a family when the member of the family that the family has been counting on for income retires. And then within 4 years the Congress said they also wanted to deal with the hazard and vicissitude that confront a family when the member of the family they have been counting on for income dies, and so the survivorship program came into the picture. Then a few years later they confronted the hazard that arises out of the fact that the member of the family that the family has been counting on becomes disabled.

But as we moved in this direction we did keep emphasizing the fact that the social insurance program, the retirement program, the survivorship, the disability program should be regarded as a floor on which individuals and private employers should build additional benefits. Now, unfortunately, in many, many instances there hasn't been anything built on that floor, or on that foundation. About 50 percent of the workers are covered by private pensions. Another percentage of people have worked out a program of their own. So that we do have a very, very large percentage of persons who are dependent almost entirely on the Social Security for an income after they retire.

I think that is one of the reasons why Congress responded to the suggestion that we bring into existence a supplemental security income program. Because actually the program that the Congress was looking at was a program that would have put an income floor under our entire population, but the majority of Congress was not ready to go that far, so they carved out the aid to the aged, blind and disabled as represented by the Supplemental Security Income Program.

But it is important for us, obviously, to keep adjusting these Social Security benefits to provide for cost of living. But in addition to that, it seems to me that it is very, very important to keep adjusting Social Security benefits in order to take care of increases in the standard of living. A President back in the early 1970's by the name of Richard Nixon actually transmitted a message to the Congress of the United States where he endorsed that particular principle. And I think we have tended to lose sight of that because of the emphasis that we have put on damage control, trying to prevent cuts in benefits. Certainly we must continue that type of damage control operation because any cuts in benefits are indefensible and do violate the compact and do undermine the Social Security System. But we have got to keep in mind the fact that Social Security beneficiaries are not only entitled to adjustments because of increases in cost of living, but certainly they should be entitled to adjustments to cover increases in the standard of living.

In addition to that, Mr. Chairman, I think we have to keep in mind the fact that we still have some inequities built into our Social Security System, particularly as far as women are concerned; and the earning sharing proposals that have been before the Ways and Means Committee, that the Ways and Means Committee requested a study on from the Department of Health and Human Services, are very, very important proposals, and I don't think that they should be pushed aside. I think they should be looked at and action should be taken on them because that is the only way in which we can iron out that inequity as it relates to women.

Mr. FORD. Mr. Ossofsky. But before I recognize you, Dr. Flemming, also think in terms of the problem that we are faced with here in the Congress with this administration offering, or talking about legislation that would delay the COLA adjustment. Thinking in terms of maybe two or three tiers, how do we pull out? Since you have served on the Commission, is it possible for us to identify the 20 percent of the recipients of Social Security who have no other income at all, who are totally dependent upon Social Security, and to somehow protect them from staying or falling below the poverty level.

The Social Security Administration has said to the Congress that it would be very difficult to have a tier 1, a tier 2, or a tier 3; and the argument that the administration is making is that there are certain recipients of Social Security who have other income and the COLA delay really would not affect them.

Just think about that a minute, and we are going to go to Mr. Ossofsky at this time and hear from him.

Mr. OSSOFSKY. Mr. Chairman, if it were possible to do, I don't think that it should be done. I think the way to deal with the Social Security System ought to be on the right of everybody to get benefits based on a period of work history and earnings.

Mr. FORD. We are talking about budget restraints. The administration is making arguments now that in order for us to meet the budget deficits head-on and to reduce these deficits that we must look at the entitlement programs. And Social Security is the primary entitlement program.

Mr. OSSOFSKY. All the more reason to act very quickly to move Social Security out of the unified budget. A good reason to stop that debate. That needs to be done quickly.

Mr. FORD. I am a cosponsor of that bill and I'm glad to inform you that the Social Security Subcommittee has reported that bill out of the committee, it will move on for consideration by the full Committee on Ways and Means.

Mr. OSSOFSKY. We appreciate your leadership in that regard. So that is a step to get away from that argument.

The other is that we gave away something in the compromise in recent years. We lost the minimum benefit in Social Security, and it is precisely the poorest who need that minimum benefit. We ought to begin assuring a floor of Social Security benefits below which nobody falls.

Mr. FORD. We don't want the poor—and I am not arguing for the administration now—I am agreeing with you; but I am wondering how do we satisfy the administration in the argument and the case that they have made before this Congress that in order for us to meet certain budget projections——

Mr. OSSOFSKY. We have already made a step in that direction—I am not sure I like the step—and that step is to tax benefits for people above a certain income. That is a way to deal with it. I am not sure I even like that way, but I don't want us to fall into a pattern of responding with answers to bad questions every time they raise an issue and a question. That is a trap for us. I think we need to reject that kind of logic out of hand. What we need to do is solve the problems of those people at the bottom of the heap, and see to it that we solve them by providing minimum benefits that are adequate.

There is one other thing that could be done, and perhaps this administration could have its arm twisted enough to do it. There are millions of people eligible for SSI who do not receive it. If we could undertake a vigorous national program to sign those people up and improve their living standards, minimal though that is, it would make a major step in improving the income of those significant hundreds of people.

Income maintenance is SSI, it is protecting Social Security, it is employment programs, it is seeing to it that we stop the hemorrhage of costs for protecting the people who are paying for health care. All of those are income maintenance issues. But I think we should not fall into a trap of providing new ways of differentiating between the levels of income of Social Security recipients, except perhaps the one we have already adopted. And that is, if your income is above a certain level some of those benefits end up being taxed back. Otherwise, we end up putting a means test into the Social Security System, whether it is on COLA or anything else, and the next stage will be to put a means test on Medicare. I think that is a road we should not travel.

Mr. Ford. Thank you. Would you also try to address the poverty threshold and bringing the supplemental security income up to the threshold of poverty?

Mr. Ossofsky. I am sorry. I am not sure——

Mr. Ford. You talked about the Social Security income, we should pay the amount at least to the poverty threshold.

Mr. Ossofsky. That is correct.

Mr. Ford. What about the Social Security minimum payment?

Mr. Ossofsky. I would be prepared to do that as well.

Mr. Ford. What about the cost that is involved? In working under budget constraints here in the Congress, we are talking about the——

Mr. Ossofsky. Give us the overrun on the MX missile, we may find the money for that program. Our problem is not lack of money. Our problem is how we spend the money, and what moneys we do not collect in our taxing system. I do not for a moment accept the notion that our problem is fiscal constraint. Our problem is that we have given back to those that could afford to pay taxes the taxes they ought to be paying, and that we are using the moneys the Federal Government is receiving for inappropriate purposes; not for human life, but for human destruction.

If we could put that back into balance, we would put our priorities straight and these kind of questions would once and for all not plague us.

Mr. Ford. Mr. Pollack, would you like to respond to that?

Mr. Pollack. I wanted to respond first to your question about what the administration was alleging; that you could cut Social Security benefits and at the same time protect low-income people. I subscribe to the statements that Mr. Ossofsky made and Dr. Flemming made about the principle of not separating the group, but I think it is also important to understand the practical impossibility of what the administration had proposed to do.

In the budget discussion that took place quite recently there were statements to the effect that we could cut the COLA and at the same time protect low-income older people. I think if one takes a look at the various proposals that were under consideration to do that, looking at it purely on the administration's terms, you will find that the administration could not achieve the objective that it indicated that it felt it could.

Specifically, what the administration said was that you could cut the COLA and at the same time you could protect low-income beneficiaries by providing some greater protection in the SSI Program and possibly by providing some tax credits for various older taxpayers. If you examine those two, in effect, safety net approaches—they are palliatives for cutting Social Security benefits—you will find that overwhelming percentage of low-income minority persons who would have been affected by the cuts in the Social Security COLA would not have been protected by those palliatives. And there is several reasons for that.

If one takes a look at the SSI Program, the SSI Program only covers people age 65 and above. So therefore, for people who are receiving Social Security benefits between the ages of 62 and 65, the SSI benefits that the administration had proposed to make would have been totally meaningless for them.

Second, there are people whose incomes are below the poverty line who are ineligible for SSI because SSI, at least as the Federal Government guarantees it, only provides 75 percent of benefits of the poverty line; therefore, for those people with incomes between 75 and 100 percent of the poverty line, the SSI Program currently does not reach out to them, and those people would have been unaffected by what the administration had proposed to do.

Finally, there is a very large number of people who are eligible for SSI who are not participating in the program, and those people also would not have reaped the benefits of the palliatives that the administration had proposed.

Finally, if one takes a look at the proposal to provide some tax credits, you will note that approximately 50 percent of all older people do not file tax forms because they have incomes below the threshold by which they have to pay taxes. Therefore, the people who do file taxes over the age of 65 tend to be in the higher income brackets and providing tax credits really would not have affected the lowest, the poorest of the poor.

Consequently, what I am saying in response to your question is that even taking the administration on its own terms it would have failed to protect the lowest income beneficiaries who are dependent upon Social Security.

Mr. **Ford**. Thank you.

Dr. Flemming?

Dr. **Flemming**. Mr. Chairman, first of all, I think I had better set the record straight. I was not a member of the Presidential Commission that looked at the Social Security set-up. I have served on quite a number of commissions, but I didn't serve on that one.

Nevertheless, I do respect very, very much the work that was done by that Commission. As you know, for example, Congressman Pepper was a member of the Commission and provided us with very fine leadership. As a result of the work of that Commission there is one thing that we can say; and that is that the system as it now stands is on a sound financial footing. The actuaries and the trustees concur in saying that it is on that kind of a sound financial footing over a period of the next 75 years. And I believe that we can accept that kind of a statement on the part of the experts in that area.

Also, it is clear that we are beginning to build reserves in the system. By 1990, for example, it will be up to $150 billion.

So that when anyone starts talking about postponing cost-of-living, making savings as far as the Social Security System is concerned, I think they have got to be reminded that those who are participating in that system have been making payroll contributions in an amount, the employers and the employees, which has provided us with the funds that we need to make the cost-of-living adjustments, for example. The money is there. We are not taking away from anybody else. It is in the trust fund, and those trust funds can only be used for that particular purpose.

And certainly we must never permit a means test to be injected into social insurance. Once you let a means test get incorporated into any part of our social insurance program, whether it is retirement or survivorship or disability or Medicare, you are undermining the foundation on which this whole concept of social insurance rests.

Now, as far as the minimum payment is concerned, there was at one time a provision for a minimum payment. That has been eliminated, and I think that that was an unfortunate action on the part of Congress. I think that concept should be reintroduced, or should be put back in the system. Because we know that the formula that establishes benefits are biased somewhat in favor of the low income as over against the middle and upper income.

But possibly that bias should be even stronger than it is. That is an issue which it seems to me Ways and Means can look at, and can look at within the present provisions for financing the system. Of course it would cost more, but there may be other adjustments that can be made that would make it possible to deal with those particular costs. I think the issue you raise; namely, the issue of the minimum payment, really, is a very legitimate issue for Ways and Means to look at.

Mr. Ford. Thank you.

Mr. Vento?

Mr. Vento. Well, I think, Dr. Flemming, that that really is the dilemma. You know, we all fought to restore the minimum benefit, and we did retroactively restore it. But prospectively, the problem was that there was a phase-out of the minimum benefit in any case. That is to say, that there was a requirement in terms of the number of years, so that if you look at the—there was a point where that minimum benefit wouldn't have been provided.

The dilemma that you present to us is that it shouldn't be means tested. But if you have a minimum benefit, to the exclusion of looking at uncovered service, as an example, as just one problem in terms of receiving retirement benefits, then you run the risk of providing someone with a minimum benefit; in other words, something above what they would otherwise earn by virtue of their wage record, as opposed to what their needs are. So that constitutes—I mean, it is a dilemma. And it is a dilemma that we face. And that is, therefore, the SSI Program taking funds from general revenue to be administered by Social Security has been sort of the answer to try and meet those needs and to try to keep Social Security out of being means tested.

Dr. FLEMMING. I agree with your analysis. But I go back to the fact that the system, the Social Security System, does have a bias, in terms of the way in which the benefit formula is worked out, toward the low income. That has been true from the beginning. I think the architects of the system were justified in doing that.

Now there is always a question of how much of a bias, and I would think that that was something that is always open to inquiry on the part of Ways and Means. I don't have any trouble with that bias being built into it.

Mr. VENTO. Well, I just think on that particular point that by virtue of the amendments that were passed in 1977, in other words, by expanding the amount of income subject to Social Security tax, we have I think substantially enhanced the low-income payout vis-a-vis a higher income payout. So I think that some of the wisdom that went into the 1977 law, which I think really is what has kept Social Security on a sound basis, not the sort of rushing into the puddle and dragging someone out of it and claim you saved them from drowning that we did in 1983. So I think what really saved it was the actions that took place in 1977 in terms of exacting the tax, and it was a stiff tax, and the sort of things in terms of expanding the amount of income that is subject to tax, which means that all of us high income folks now have the privilege of paying a lot more in tax than we had before and perhaps not getting back, on a formula basis, as much as we would otherwise have received.

So I think that some of that, and I think that the committee certainly should look at ways to try and enhance the low income. I think there is great merit in terms of people feeling that they have earned these particular benefits and not wanting to appeal to SSI. And there are many that will not simply because it is means tested.

Mr. FORD. Thank you.

I would like to move right into "Health Care for the Elderly" at this time. Before we get into it I would just like to go over some data that I have before me that states: perceived health status, more than one-half—55.1 percent—of all blacks 65 or older consider their health to be poor or just fair; approximately one out of every four aged blacks view their health as excellent or very good; the remaining 20.5 percent consider their health to be good.

Now, in comparison with whites, aged whites are more likely to have a positive view of their health status: 35.2 percent consider their health to be very good or excellent, compared to only 24.5 percent of the elderly blacks; about one out of three whites 65 or older view their health to be fair or poor.

Now, when we talk about restrictive activity days, aged blacks and elderly whites, restrictive activity days for aged blacks is nearly 41 percent higher than for elderly whites, which is 43.4 days versus 30.8 days.

Take bed days, aged blacks and elderly whites. Older blacks are confined to bed, on average, approximately 58 percent more than aged whites; that is, 22.3 days versus 14.1 days per year.

That data was received from the Department of Health and Human Services.

I would like to hear from at this time Ms. Frances Humphries, the Washington representative of the National Gray Panthers, along with Mr. Ronald Pollack, the executive director of the Villers Foundation.

STATEMENT OF FRANCES HUMPHRIES, WASHINGTON REPRESENTATIVE, NATIONAL GRAY PANTHERS

Ms. Humphries. Good morning. Thank you, Congressman Ford. It is my pleasure to be here this morning.

I want to say at the outset that I am the Washington representative of the National Gray Panthers, and that is a pleasure because we have opened our new office in Washington. So this is an exciting week for us.

The Gray Panthers is an organization of 60,000 members and supporters who advocate for basic human rights. We oppose discrimination on the basis of age, color, or any other factor of the human condition. But today I want to speak to you in the capacity of chairperson of the National Health Task Force of the Gray Panthers, and my comments will be focused on the older black woman who is not classified poor by legal definition, but nonetheless, she experiences a tremendous financial dilemma in stretching a Social Security check far enough to cover basic living expenses and purchase health care.

According to a Social Security Administration statistic, 69 percent of all older single black women had incomes at 125 percent of the poverty level in the year 1982. One hundred twenty-five percent of the poverty level in that period would represent a monthly income of $510. Now last year, in 1984, that would have been a monthly income of $519. That figure, very minimal, is nevertheless enough to render these women, or men for that matter, ineligible for Medicaid. As a result, for them health care rationing is already in effect.

To illustrate this dilemma, I want to cite a specific example. The case study that I am going to present to you is an actual person; not a composite of a lot of people, but an actual person. This woman's name is Ann. She is 79 years old. She lives alone. She owns her home; it is paid for. Social Security is her only income. That income is $478 a month. Out of that $478 a month she spends about $300 for groceries and housing expenses and the kinds of personal expenses that everybody has to spend money for—clothing, that kind of thing.

Let me say that on $300 a month those kinds of expenses are kept to a bare minimum. After she spends that she has $178 left, and that has to cover emergencies and health care, a big expense. In addition to just paying the doctor bill and that kind of thing, this $178 has to cover insurance premiums that most elderly pay for insurance policies to supplement Medicare. It also covers the kinds of health care needs that Medicare doesn't cover, like prescription drugs, foot care, eyeglasses, dentures, and Medicare deductibles and copayments, and physician overcharges when a doctor does not accept assignment. They charge more than Medicare deems a reasonable charge, then the beneficiary pays that. So that is what Ann has to pay out of her $178.

Health care is a big expense for this woman; she has a chronic condition. In that respect she isn't unique. She is like a good portion of the elderly; 86 percent of the elderly suffer at least one chronic condition. In Ann's case it is osteoporosis; and as a result of that condition, she suffered a broken hip about 2 years ago, and more recently it was a broken arm. Each episode has been very costly.

In the period covered by this report, January through September 1984, her doctor bills totaled $789. Of those charges, Medicare paid $162 and her supplementary insurance policy paid $123, a total of $285. That left Ann to pay out of pocket $504. Needless to say, the physician that she was referred to, the bone specialist that she was referred to did not accept Medicare assignment.

In addition, during that period Ann paid $279 for this Medicare supplemental health insurance and $270 more for medicine. So those three items totaled, out of pocket, $1,053. If we added the Medicare part B premiums that are automatically deducted from her Social Security check, the total would be $1,184. This is for a woman on a monthly income of $478.

The bottom line is that this woman paid 24 percent of her monthly income on health care, and the health care that she received for that wasn't even adequate. It was in response to an emergency need, it was all for that broken arm. It didn't address any of her ongoing health care needs.

When she isn't worrying about her current medical bills, she worries about future ones. Her health is declining and the cost of health care is continuing to rise. So for her the possibility of not being able to afford to go to the doctor is very real.

This struggle helps us to visualize the plight of thousands and thousands of women, many of them black. This cuts across all color lines. These women are trying to survive and deal with this inflated cost of health care on incomes no greater, and in some cases less, than Ann's. The question that we have to be left with is how are they going to do this?

Thank you.

Mr. FORD. Thank you very much, Ms. Humphries.

I am sorry, Mr. Pollack, I thought that you were on the panel, for it is here on my schedule, for health care. But I understand you want to speak on income maintenance.

Prior to recognizing you—Mr. Ossofsky, let me ask you: could you give us your view as it relates to health care? I understand that you have a background in the area of health care for the elderly. Do you see any acute problems in health care similar to that described by Ms. Humphries, a 79-year-old woman on a fixed income of $478 per month? Can you give us somewhat of an overview as it relates to the elderly on fixed incomes in trying to make ends meet, and how they are denied health care?

Mr. OSSOFSKY. Regrettably, what we have just heard is rather typical, Mr. Chairman. The testimony I submitted will give you some statistical evidence which underscores the fact that a high proportion of older blacks may see a physician, for example, when they know they need to see one because of concerns of costs.

The other problem is one of accessibility tc health care. One study underscored that 20 percent of the population is lacking adequate access to physicians both in rural areas and in central cities. This can in no way ignore the plight of older blacks in particular. What we have got to do is take a look at what is going on, particularly in the last few years—an increase the cost of Medicare, of the cutbacks that the States have made because of Federal cutbacks to them in Medicaid, and the increase in eligibility and the reduction of services.

The fact of the matter, just as Dr. Flemming referred to it in the areas of so many aspects of income maintenance, we have been in a holding and defensive action on health care. We need, really, to make progress in improving Medicare, not just in plugging the gaps.

In Medicaid as well. We still do not provide drug coverage out of a hospital. We don't provide for appliances—for eyeglasses, for dentures, for hearing aids. Medicaid, itself, largely is skewing the health care system to institutional care, and older blacks have considerable difficulty in finding adequate resources when they need institutional care. A very high proportion, some 95 percent of the black population in one study we undertook, that is mentioned in the study, called for a major priority on the development of inhome, community-based services for the delivery of care for those who don't need to be institutionalized. And particularly in black communities there is a paucity of such resources.

Interestingly enough, some 87 percent of the total public in all straits and striations of the society expressed a willingness to provide tax money if such increases and improvements in the benefit programs would be made available.

We face some real tragic circumstances for older blacks which reflect the circumstance in our health care delivery system. It is fragmented. In many places it is more characterized by its gaps and nonexistence. We have got to begin doing something to quickly restructure the system, not only for the old, but for the young as well.

Dr. Flemming made reference to the Kennedy-Gephardt bill. I believe we really have to begin looking seriously at a national health insurance program, which we find increasingly people across the country are no longer stopping at, that will provide adequate comprehensive health care for all aspects of our population. Do some things to train physicians, and encourage them to go into the areas where the older poor blacks, in particular, live, and start afresh. Start afresh.

One of the most significant things that could be done is to mandate that the payment for Medicare benefits that physicians receive is all that they can get from the patients. Mandate acceptance of those fees. We have done it in State after State with workman's compensation. I don't understand why it cannot be done as far as Social Security is concerned.

In other words, we are facing a real tragedy here in availability, access, and coverage; and we have got to do something very dramatic very fast.

Mr. **Ford**. I think Dr. Flemming has an observation here.

Dr. **Flemming**. Mr. Chairman, I appreciate that because we do face I think a very serious crisis in the whole health care area. I believe that there are things that can be done that will bring about an improvement. I feel that the passage of a bill which contains at least the thrust of the Kennedy-Gephardt bill is a must because then we can carry on this discussion within a more favorable climate. If the country is convinced of the fact that action has been taken to bring the spiraling cost of health care under control, then we have got a chance to get people to focus on the weaknesses in Medicare and the weaknesses in Medicaid.

As far as Medicaid is concerned, I would like to underline something that I just mentioned briefly in my opening statement. I was around when Medicaid came into existence. Its purpose was to meet the needs of the medically indigent. But it has evolved in such a way that we have millions of persons who are medically indigent who can't qualify for Medicaid because they can't meet the requirements for going on welfare.

Let me be very specific on that. I did chair a board of inquiry on health care that held hearings in 11 communities throughout the country. I will always remember one witness in Kansas City, who was a truckdriver earning $16,000. He and his wife have a son 14 years of age who was born with a birth defect, required constant medical care. A year ago when we held this hearing their bills for 1984 totaled about $4,000. They confronted minor surgery which would add another $2,000.

His earnings as a truckdriver are $16,000. That means he can't qualify for any means tested program. He works for an employer that does not have a health care plan, so he isn't under any private health care plan. He was questioned as to whether he had explored the possibility of taking out a policy as an individual. He said yes. He had a number of quotations. The lowest quotation was $504 a month.

Well, by any reasonable test that gentleman and his wife are medically indigent, but they can't qualify for Medicaid. And that it seems to me is an issue to which Congress should address itself.

I would like to end by saying I concur completely with Jack Ossofsky that if we could get this cost containment legislation through, we could then give serious consideration to an improvement of Medicare. But beyond that, we could give serious consideration to the enactment of a national health plan. We cannot live much longer with 35 million people in this country not having access to any kind of a health care plan, public or private.

Mr. **Ford**. Thank you, Dr. Flemming.

We are going to move into the "Overview on Aging Legislation," and we are going to place you, Mr. Pollack, right before the first witness, which will be Mr. Samuel Simmons, the executive director of the National Caucus and Center on the Black Aged. Also, we will hear from Mrs. Shirley Bagley, the assistant director of Special Programs for the National Institute on Aging; also, Mr. Herbert R. Doggette, Jr., the Deputy Commissioner of Operations at the Social

Security Administration; along with Dr. Joyce Berry, Acting Associate Commissioner, Office of Program Development for the Administration on Aging.

We will recognize you, Mr. Pollack, at this time.

STATEMENT OF RONALD POLLACK, EXECUTIVE DIRECTOR, VILLERS FOUNDATION

Mr. **Pollack**. Thank you, Mr. Chairman. I am delighted to have the opportunity to participate in this session. I had hoped to focus on aspects of income security, although I am struck by the tremendous correlation that exists on the issues of income security and the questions of health care.

If one examines the agenda that was discussed earlier—we talked about eligibility and benefit levels in the SSI programs—it is extraordinarily important to recognize that for many people their true access to health care is predicated on their participation in the SSI Program. And the reason for that is that Medicaid eligibility for low-income elders comes about as a result of one's participation in the SSI Program. Simply put, if one is ineligible for SSI, one is ineligible for Medicaid by and large. And therefore, if a person who is low income is ineligible for Medicaid, then that person needs to confront the various inadequacies that currently exist in the Medicare Program.

Costs in the Medicare Program have skyrocketed tremendously with respect to the burden that is currently being shared by participants in that program. We do not have any policy other than the most recent implementation of the DRG system that really meaningfully tries to grab a hold of rampant cost escalation in the health care system. We have a policy of cost shifting, not a policy of cost containment, and the cost shifting is now being borne on the backs of lower income elders.

We have rampant increases in the costs that elders have to experience now in the Medicare Program. The part A deductible under Medicare has reached $400. It is slated to go up by approximately $75 more in the next year. The premium under part B costs almost $200 a year, and this does not even cover, as was alluded to before, such things as prescription drugs, eyeglasses, hearing aids, prostheses, and, of course, long term care. And as a result, lower income elders who do not have the protection of the Medicaid Program are being impoverished more and more.

What I did want to focus on, Mr. Chairman, in my discussions, to some extent because I recognize the fine leadership that you have provided through your chairmanship of the Subcommittee on Public Assistance, I, too, wanted to focus my comments briefly on income security and the relationship of concerns about income security to the SSI Program that was talked about earlier.

We have, in the last month, been heralded with news that the poverty statistics have made some minor improvements, which mask, unfortunately, the fact that incidences of poverty have risen dramatically throughout the age spectrum over the past several years. While it is true that poverty incidences have not increased among elders, among poor people by and large it has increased very significantly.

I noted a recent report that was issued by CBO—Congressional Budget Office—which tried to assess the impact over the past several years of the changes that Congress made in 1981 with respect to various benefit programs, as well as taxation, and how they affected people in different income levels. I find that the statistics provided by the Congressional Budget Office tell us very eloquently that contrary to what we were fighting years ago, the war on poverty, we are now fighting the war on the poor.

What the Congressional Budget Office said, only within the past year, was it took a look at what the impact was of various Government benefit programs that have been cut back as well as changes in tax policies and it analyzed it based on quintiles—meaning it separated it into five population classes. And looking at the lowest income group, it looked at people with household incomes below $10,000 a year. It compared that with people in other quintiles including people in the highest income bracket, those people in households with incomes in excess of $80,000.

What the Congressional Budget Office did was it took a look at what were the gains that each of these families experienced as a result of tax cuts, what were their losses in cash benefits, and what were their losses in noncash benefits such as food stamps and health care. What the Congressional Budget Office found I think is truly astounding.

With respect to households with incomes less than $10,000 a year, the gains that they experienced in the tax cuts was $20 a year. What they lost in cash benefits, however, was $250 a year and what they lost in noncash benefits was $160 a year. Therefore, for the average household with income below $10,000, they experienced a net loss of $390 a year.

Juxtapose that with households with incomes in excess of $80,000 and you see what kind of distribution of income we are now experiencing. For households with incomes in excess of $80,000, they received a tax gain as a result of the tax cuts of 1981 of $8,390. They experienced a loss in cash benefits of merely $90 and they experienced a loss in noncash benefits of merely $40, which means that the net change for a household with income above $80,000 a year was a plus $8,270. And I say how in the world can we justify in fairness that households with incomes below $10,000 experience a net loss of $390 while we distribute a benefit, an increase, for households of $80,000 or more of $8,270.

Well, with respect to the elderly, and particularly minority elderly, we are told that elders are faring better. And it is fair to say, if one takes a look at what has happened with respect to elders' incomes since 1973, their income situation has remained relatively stable. But that fails to tell us who has been left behind and who is experiencing difficulties that I think can be described in many hours of very painful testimony.

With respect to the black elderly, one in four persons over the age of 65 are experiencing incomes below the very meager poverty threshold. For Hispanic elderly, one in five elderly persons is experiencing an income below the poverty line. For women, approximately 17 percent of women who are over 65 years of age have incomes below the poverty line, but for black elderly women, two out of every five black elderly women have incomes below the poverty line. We are told that the median income for a single elderly woman is merely $400 above the poverty line; for black women, it is well below that.

Now the question I think is what is it that we can practically do about it? And perhaps I am preaching to the choir, but I think it is very important that we focus once again about the SSI Program because I think within the SSI Program we do have a way by which we can try to make sure that everybody has income above the poverty threshold. Currently the SSI Program provides a monthly income of $325 a month, which is an extraordinarily meager amount to eke out an existence. It provides approximately 75 percent of the income of even the meager poverty threshold. For a two-person household of elders, the SSI Program provides merely $488 a month, also wholly inadequate.

Now what are the States doing to try to correct that? If one analyzes what is occurring in the 50 States plus the District of Columbia, we know that the States have the option to supplement those benefits. Unfortunately, however, approximately half the States refuse to supplement those benefits. Only 26 States plus the District of Columbia provide any supplementation whatsoever. The average monthly supplementation in the States that do supplement is merely $36 a month. There are only 10 States that provide supplementation in excess of $50. And if one takes a look at what supplementation does exist, one finds that over the past few years in real dollars the supplementation levels have decreased.

Your subcommittee and the Committee on Ways and Means has documented what has occurred with respect to supplementation of benefits with respect to SSI. And in the period from 1980 through 1984, just taking a look at the decisions of State governments, only two States in the country—New Jersey and Wisconsin—increased their supplementation levels to keep pace with inflation. Only three States had supplementation levels added onto the basic Federal level that provided incomes in excess of the meager poverty threshold.

Now what do these statistics actually mean? And what does it mean with respect to how people face their lives? We had the privilege to provide some funding to an organization that tried to make some assessment of that. We gave money last year to the National Consumer Law Center to take a look at what is the experience of people who are participating in the SSI Program in meeting their daily needs.

What the National Consumer Law Center did, in a publication entitled "Polled Not By Choice: A State-by-State Analysis, the Impact of Energy Prices on the Poor, Elderly and Unemployed," was it took a look at what happens to an elderly person who is subsisting on the SSI Program after they pay their monthly energy costs, particularly during the three coldest winter months of December, January, and February. What the National Consumer Law Center found is truly astounding.

What they did was they took a look at what was the average prices that people pay for their energy bills during those three coldest months of December, January, and February and it compared those average costs of energy costs with the maximum amount of benefits that such a family could receive under the SSI

Program. I stress it compared it with the maximum benefits that a household could receive under the SSI Program.

What they found is that in 47 States plus the District of Columbia there was merely $61 left per week for all necessities after an SSI household paid for its energy costs. In 35 States plus the District of Columbia, less than $50 remained for all necessities—food, clothing, shelter—after energy bills were paid.

The SSI Program clearly provided a promise when it was first established in 1973. It was a promise by which there would be a guaranteed income for all people who were aged, blind and disabled. And unfortunately, what we must face, what we must confront is the fact that that guarantee is a guarantee that is unacceptable. It does not approach anywhere near minimally acceptable levels.

Not only that; those people who are eligible for assistance must be so impoverished that they are clearly the poorest of the poor. When the SSI Program was established in 1973 the amount of assets that a household could have in order to qualify was merely $1,500 if one lived all alone, and merely $2,250 if one lived with someone else. Congress has now increased that $1,500 level to $1,600, despite the fact that since the program was established inflation has increased by 120 percent.

Now it seems to me that when we address the question how can we end poverty amongst elders, I suggest, Mr. Chairman, that the SSI Program is the vehicle by which this can be accomplished. The SSI Program, if properly structured, can cover everybody above the age of 65 who is poor. Now, if we were to bring all of those people up to the poverty threshold, the cost of that would be approximately $5 to $6 billion. That may not be extraordinarily consequential in terms of the importance of that objective, but I think all of us are aware that Congress is functioning currently in a period of fiscal austerity.

I certainly subscribe to the statements made by Mr. Ossofsky about our priorities with respect to the budget. I suggest that, while I subscribe to those comments, I think there are some practical steps that we can take even in this context of political reality.

One of the things that the Villers Foundation proposes to do—and I hope to share the findings of this with your subcommittee, Mr. Chairman—is we want to take a look at what are politically feasible means by which we can finance this agenda to bring all people over 65 years of age and the disabled and blind participating in the SSI Program up to the poverty line. The price tag, as I indicated, is approximately $5 to $6 billion per year, and I understand that Congress is not about to increase the deficit by $5 to $6 a year. What we hope to do, working together with the Urban Institute and other experts, is to take a look at various options that might be viewed as feasible options for financing this agenda so that all persons above 65 can be brought up to at least the poverty threshold.

I suggest one example of that that may well be somewhat controversial, but I think the kinds of alternatives that we need to look at if we are going to try to seek some kind of equity in terms of income structures for people around the country. One of the benefits that elders receive currently is a benefit that they receive as a result of IRS provisions pertaining to double exemptions. Those double exemptions which provide an increase in tax savings for elders is disproportionately provided to the highest income elders. The cost of that to the Federal Government currently reaches approximately $2.5 billion. Those tax expenditures are expenditures which are not distributed to lower income elders.

I suggest that we may have to, in this era of fiscal austerity, make some hard decisions, and I am prepared as one person to try to make some of those hard decisions and to have us examine those. Not exclusively. I think we have to take a look at the kinds of fiscal priorities that Jack Ossofsky mentioned before, but I think we also have to recognize that we can't lament the fact that there are people below the poverty line and suggest remedies that we know are going to be politically unfeasible.

I suggest that there are ways that are not necessarily intergenerational transfers that are going to make sure that low-income elders, minority elders can have benefits financed in ways that are not going to hurt lower and lower middle-income people. And I am hopeful that the findings of this study, which will be concluded sometime in the spring, can be examined by policymakers and by others who are interested in the agenda of the Congressional Black Caucus because I think that we have some practical ways by which we can start making some inroads in poverty amongst the old in America.

Mr. FORD. Thank you very much.

Mr. Simmons?

STATEMENT OF SAMUEL SIMMONS, EXECUTIVE DIRECTOR, NATIONAL CAUCUS AND CENTER ON THE BLACK AGED, INC.

Mr. SIMMONS. Thank you very much, Congressman Ford and Mr. Vento. First of all, Dr. Aaron Henry, who is our chairman, evidently got delayed on the plane this morning and he is unable to be here. So with your permission, I would like to make his written testimony a part of the record.

Mr. FORD. Dr. Henry's testimony will be made a part of the record, Mr. Simmons.

[The prepared statement of Aaron E. Henry, cochairman, National Caucus and Center on Black Aged, Inc., follows:]

PREPARED STATEMENT OF AARON E. HENRY, COCHAIRMAN, NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

Congressman Ford, I appreciate the opportunity to testify again before the Congressional Black Caucus. It is always a pleasure to appear at your hearings. In fact, I consider the Congressional Black Caucus week to be one of the highlights of the year.

I realize that your time is limited. Consequently, I shall keep my remarks brief and focus immediately on the subject at hand: "The Impact of Health Budgetary Cuts on the Black Elderly."

This is both a timely and critical subject. This issue unfortunately will probably remain in the forefront in the years ahead.

Budget cuts have decimated older Blacks during the past four years in practically all aspects of their lives. Health and housing, though, are the two areas where the greatest damage has been inflicted, driving the low-income elderly misery index to new heights.

Medicare and Medicaid represented hard fought and well-deserved landmark legislative achievements for aged Blacks and other older Americans. Today many Americans erroneously believe that Medicare and Medicaid cover almost all of the elderly's health care costs. Older Americans, though, know better.

The harsh reality is that Medicare and Medicaid protection is being whittled away by cutbacks in coverage. Increased deductible charges and other cost sharing arrangements are reducing the already limited income of aged Blacks. The bottom line is that elderaly Blacks are paying more for less protection.

In addition, they continue to be victimized by our two-tier health care system which provides "welfare" medicine for the poor but quality care for the more affluent in our society. This is apparent in so many ways. Older Blacks, for example, are more likely to wind up in unlicensed boarding homes or Medicaid "mills". They are more likely to be abused and humiliated by insensitive or uncaring health care staff. Perhaps the clearest manifestation of this is the shorter life expectancy for Blacks than for Whites.

A. INCREASED OUT-OF-POCKET PAYMENTS UNDER MEDICARE

Older Blacks are losing the battle of the health budget by any objective standard. The last four years have produced, to a very large degree, a steady stream of defeats in the health arena. About the only good thing that can be said about this sad chapter in our history is that "it could have been worse." This is not much comfort, though, to older Blacks who have been victimized by these harsh cutbacks in health coverage. Fortunately, the Congressional Black Caucus and other concerned groups have prevented further cuts.

However, aged Blacks had still suffered considerable damage. The elderly's out-of-pocket payments for Medicare have increased markedly during the past four years. The Medicare Part A Hospital Insurance deductible has jumped by 96 percent, from $204 in 1981 to $400 in 1985. At the present time, the Part A deductible is ten times the level when Medicare began operations in 1966. It will rise again this coming January.

The Part B Supplementary Medical Insurance deductible has increased by 25 percent, from $60 in 1981 to $75 now. The Part B premium has jumped by 50 percent, from almost $124 annually in 1981 to $186 in 1985.

These increased out-of-pocket payments were accelerated, to a large degree, by the 1981 Omnibus Budget Reconciliation Act, which made key changes in the Part A and Part B deductible charges. The 1981 Reconciliation Act and the 1981 tax reduction were supposed to pave the way for balancing the budget and providing economic prosperity for all.

On both counts, the Administration's economic package has struck out. The excessive and ill-conceived tax reductions, which primarily benefited the most affluent in our society, and the Pentagon's insatiable appetite for more money have produced the largest deficits in the history of our nation. In fact, the deficits during President Reagan's two terms will exceed the entire amount amassed by his predecessors during the prior 192 years.

Instead of spending more and more to destroy life in some distant land, I think that we should protect programs like Medicare and Medicaid from further cuts.

B. MEDICAID CUTS

Medicaid has also suffered heavy reductions. These cuts have adversely affected older Americans because about one out of every six Medicaid recipients is 65 years or older. Aged Blacks have paid a greater price because they are more likely to need Medicaid since they are three times as likely to be poor as elderly Whites.

The 1981 Reconciliation Act produced Medicaid cuts because federal matching payments to states were generally reduced by 3 to 4.5 percent from 1982 to 1984. This has led to cutbacks in long-term care and other health services.

New copayment charges for certain services will erode Medicaid protection further for older Blacks. Fortunately, some exemptions are available for patients in skilled nursing facilities, intermediate care facilities, and those requiring emergency services.

The so-called Tax Equity and Fiscal Responsibility Act will make it easier for states to impose liens on the property of Medicaid recipients if a spouse or dependent child is in the home. This may discourage low-income aged persons from seeking Medicaid because of the demeaning connotations associated with liens on property.

C. MEDICAL AND DENTAL DEDUCTIONS

Affluent taxpayers have reaped all kinds of tax breaks in recent years. Architects of these measures insisted that the rich will use these tax savings to benefit our economy, which will trickle down to help the most economically deprived groups in our society. This simply has not been the case. The affluent have used their tax savings largely to purchase more imported goods, take trips to Europe or other exotic places or move up from the BMW to a new Mercedes-Benz.

But this loss of revenue has forced tax savings in other areas. Aged Blacks and other older Americans have lost tax benefits under these circumstances. One example is the medical and dental deduction which affects elderly taxpayers much more so than younger taxpayers. The so-called Tax Equity and Fiscal Responsibility Act made it more difficult for senior citizens to deduct medical and dental expenses. First, it abolished the provision allowing taxpayers to deduct one-half of their medical insurance premiums, up to $150. Second, the law raised the floor from 3 percent to 5 percent of adjusted gross income before taxpayers can claim medical and dental expenses.

The net effect is that older Americans will receive less tax breaks from the medical and dental deduction. They must pay more out of pocket before receiving any tax benefits.

D. FISCAL YEAR 1986 PROPOSED BUDGET CUTS

The Administration's fiscal year 1986 budget proposed further cuts for Medicare, the most important program for older Americans after Social Security. In fact, Medicare was targeted for the biggest reductions for programs serving the elderly.

Many of these recommendations—several of which were nothing more than dusted off versions of earlier proposals rejected by Congress—would either reduce protection for the low-income aged or increase their out-of-pocket payments.

One example is the proposal to delay Medicare eligibility until the month after a person becomes 65. Many older Americans could be caught without health insurance after they retire under this proposal. They could easily be wiped out financially if they are unfortunate enough to have a costly illness during this period.

Older Americans would also pay much more for their Medicare Part B coverage under the Administration's plan. Specifically, the Part B premium would finance 35 percent of the program costs, compared to 25 percent currently. This may sound relatively harmless, but it certainly is not. Aged and disabled persons would pay $322 million more in 1986 and $11.5 billion over the next five years under this plan.

A new home health copayment charge—estimated at $4.80 per visit after the 20th visit—would become effective in 1986 under the Administration's Medicare package. This would add to the elderly's growing out-of-pocket payments under Medicare.

A $1-billion cut in Medicaid is proposed by capping federal payments. Here again, this recommended reduction would hurt aged Blacks in particular since they are much more likely to need Medicaid than other older Americans becuase of their low-income status. The $1-billion savings would grow to $16.6 billion over the next five years.

E. EMERGING ISSUES

Medicare will continue to be a dominant issue on the horizon because an advisory committee projects that the program will need large sums of money in the near future. The council has tilted heavily toward benefit reductions—as opposed to raising revenue—to strengthen the financing of the program.

The centerpiece is a proposal to boost the Medicare eligibility age from 65 to 67 from 1985 to 1990. This would produce almost $75 billion for the Medicare Hospital Insurance program through 1995. Much of this so-called "savings" would come out of the hides of older Blacks and other aged minorities who have a shorter life expectancy than Whites. Recent government statistics make this point very convincingly. The average life expectancy for Black males, for instance, is less than 65 years.

Another key element is a restructured Medicare benefit package. Several sweetners are provided, including unlimited hospital impatient days and a cap on out-of-pocket expenses for covered Part B services for persons electing the enhanced Part B benefit. But, there is a catch to the advisory council's package. Medicare patients would be subject to a daily coinsurance charge equal to 3 percent of the hospital deductible after they meet this front end charge (currently $400) if they do not elect the Part B coverage. Moreover, the Part B premium would rise. The bottom line is that this proposal would save $13 billion over a ten-year period and provide $25 billion in additional revenue during this time.

F. CONCLUSION

These measures must obviously be defeated if they resurface again. We must also be vigilant of other proposals which will hurt older Blacks.

My message is blunt and simple. The battle of the budget—especially in the health arena—is an ongoing confrontation. We must be armed with the facts to take on directly the economists and other staff who know the cost of everything and the value of nothing.

Older Blacks have already been hard hit by prior budget assaults on Medicare, Medicaid and other health programs. We cannot let it happen again because if we fail, more older Blacks will slip below the poverty line.

We have lived through dark chapters in our history and have survived. In some cases, we even won important victories. We can do the same in the future if we are united and resourceful. And, the Congressional Black Caucus can provide the unifying force to assure that future budgets are fair for aged Blacks and other older Americans.

Mr. SIMMONS. And also, in terms of my own written testimony. I was sitting here thinking about what it was, and essentially what it boiled down to is much of what you have already heard. You have heard about how intense the problem is. You have heard about the plight of the black elder, and it is nothing new for you. And you have also heard about the fact that there is entrenchment in Federal programs today. You have heard this before. You hear this time and time again. And you have also heard that even if the programs were funded as they were a few years ago it still wouldn't be enough.

So we go to meeting after meeting and we hear all of this erudition. We all of these facts and we hear all of these figures. And a good many of you can go back home and be very articulate in terms of making a similar speech. You go back home and you report, and you tell all that went on here today. And you are going to come back next year and you are going to do the same thing.

So instead of talking about my presentation today, I want to talk about another approach, another activity that we at the National Caucus and Center on the Black Aged have underway. And really, that is alternative strategies for us as black individuals, for us as black community leaders, for us as black organizational leaders to do something about it.

And really, what we advocate is a twofold strategy: One—we have created something we call a National Advocacy Network for the Black Elderly. It is a social action effort, it is nongovernment funded, and the main purpose of that movement—it is a movement, it is not an organization, the main purpose of that movement is to try to impact on the political system, to become knowledgeable about what the specific issues are, to write letters to Congressmen, to visit Congressmen, to try to mobilize individuals on the local level to do something about all of these issues that you know about. And it is very important that we do that.

It is very important that we work with the elderly, so that they can become more effective as their own advocates. Because when all is said and done, very often the most important person to offer testimony before Congressman Ford is not someone who is 58 or 59, but someone is 85 or 86. This is the kind of thing that has impact. And so I think it is awfully important for us to really try to find ways, instead of just informing ourselves of what the issues are, to find ways to mobilize and to energize the black community to undertake social action.

One of the things, for example, that we are doing right now is we are writing to every black elected official in the United States asking them to become a part of the NANBE network. We think it is important over and above the other things that they are doing to be an integral part of this network because of the magnitude of the problem, because of the need of the problem.

The other side of this alternative strategy is service. You know, in the black community historically we have a fantastic tradition of helping our neighbor, of helping those less fortunate. And tragically, I would say, that as we become more and more urbanized you see less and less of that than you have in the past. So I think it is important to really undertake a vital service program on the part of all organizations.

See, we at NCBA feel that every nonelderly organization in the United States—church, lodge, fraternity, or sorority—ought to have some kind of ministry to the elder, some kind of mission to the elder. Now that mission or ministry does not always have to be important. I will tell you in a few minutes about some that are big and important. It can be something simple.

I met with a national group who said that they didn't have any money, and the first thing that they wanted me to do was to help them write a proposal to be able to get money from a foundation to be able to undertake a service program for the elderly. Well, I started off by telling them that the foundations are just like the Federal Government; they are cutting back on the amount of money that they have available. And if you want to really do something that is vital and important, don't start off writing a proposal. Start off by trying to figure out what is it that you can do with your own resources.

There is no national organization that is too weak, too small to undertake a service program. And if someone tells me they belong to a national organization like that, I would say that that national organization should not call themselves a national organization.

Now some of the kind of things that a national organization and its affiliates can do. It can be something as simple as a telephone reassurance program that its chapters run throughout the country, just keeping track of elderly people in a community or connected with an organization. I have worked with a church group in a community who have undertaken a weekend nutrition program. You know, an interesting thing is the Federal Government feels that older people don't get hungry on Saturday, Sunday, and the holidays. The nutrition program runs Monday through Friday. So the older people, they just say, "I got enough to last me until Monday." You know that is not true and I know that is not true.

The thing that we did in one community was in terms of encouraging a group of churches to come together, and they have a weekend nutrition program where they donate. They didn't get any money from the Office on Aging. They didn't write a proposal. They use their own resources to be able to provide nutritious meals on holidays and on the weekends. That is another kind of thing that can be done.

Other kinds of things that your national organization or group of local organizations can do is information and referral. You heard here this morning about how many people are not on SSI who are eligible for it. Now why is that? It is that way because of the fact that very often the black older people don't know what they are entitlements are. Maybe this sophisticated, urbane organization does nothing but provide information and referral services.

Now, if you say that your organization is bigger than that, more sophisticated than that, then you can undertake the kind of programs, for example, that Bob White and the National Alliance of Postal and Federal Employees have undertaken. Here is a trade union representing Federal employees. Representing people who are in the Post Office and Federal agents. And today, since 1979 they have been able to put together and put in operation about 15 million dollars' worth of housing for the elderly. Bob will also tell you that they are about ready to start another $4.5 million project. So if your organization is on that level, that is a kind of activity that you can undertake.

But to summarize what I am all about this morning, I am here to say it is not enough for us to know about the plight of the black elderly and all of the statistics on pathology. It is not enough for us to know about all of the different variations in terms of what we need to do on the Hill. The important thing is what are you going to do about it when you go back home beside report and talk about it and come back here next year to hear the same thing to go back to do it again. The major thing is that I am saying to each and every one of you as an individual, as a member of a local organization, as a member of a national organization—you have the responsibility to get something underway from the standpoint of social and political action, and also from the standpoint of direct service to the elderly. If we do that I think we will improve the quality of life for black older people in this country.

Thank you.

Mr. **Ford**. Thank you very much, Mr. Simmons.

Mr. Simmons, I will state that this is a full committee session today with the Committee on Aging. I would like to thank the full committee chairman, Mr. Roybal, for his leadership as it relates to the issues on the black aged and aging in general. Also, the members of this full committee on both sides of the aisle. The testimony today certainly will be considered by the full committee in making recommendations to the Congress.

We are very delighted to have each panelist participating today in this group of delegates who are here for the 15th annual convention of the Congressional Black Caucus. We decided this year we would do it in conjunction with the full Committee on Aging, so we could have not only today's testimony as a part of the record but also to have our recommendations considered for action in the remaining part of this session of the Congress as well as the 1986 agenda.

[See appendix 3, p. 58 for National Policy Recommendations.]

Mr. **Ford**. At this time, Mrs. Bagley.

STATEMENT OF SHIRLEY BAGLEY, ASSISTANT DIRECTOR, SPECIAL PROGRAMS, NATIONAL INSTITUTE ON AGING

Mrs. **Bagley**. Thank you, Mr. Chairman. I am very pleased to be with you this morning to describe briefly some of the programs of the National Institute on Aging in the area of minority aging, and especially in the area of black aging.

First of all, the National Institute on Aging has a legislative *mandate to both* conduct and support research on the processes of aging as well as the special needs and problems of the aging. This research ranges from basic biological research to research at the societal level, including the impact of older people on social institutions and the impact of social institutions on older people.

In view of the fact that individuals grow old under varying social and cultural conditions, research on variability among racial and ethnic groups is an important part of our program. In general, life expectancy, health status and environmental influences have been less favorable for minorities. The proportion of the population which is elderly varies considerably by race and ethnic origin. Over the last decade the elderly white population grew by about one-fourth, but the black elderly population grew by one-third.

The black population has grown at a faster rate than the white population partly as a result of the more rapid gains in life expectancy experienced by blacks. In 1900, the average life expectancy at birth was 16 years higher for whites than for blacks. By 1978, however, that difference had been reduced to 5 years. In 1983, about 8 percent of the population 65 years of age and older was black. By the year 2050, blacks are projected to make up over 14 percent of the older population. Also in 1983, 12 percent of elderly whites were below the poverty line, compared to 36 percent of elderly blacks. Therefore, this forum on black elderly in poverty is very timely.

The National Institute on Aging supports a variety of projects on minority aging. We have a standing request for applications directed to social and behavioral research on minority aging which over the years has drawn many applications and resulted in a number of these applications being actually funded. Research on aging and minorities provides not only the opportunity to learn more about minorities and aging, their particular problems and especially their strengths and adaptability; but also, by comparison, provides the opportunity to learn more about aging in the majority population.

The request for applications just referred to focuses on research on sociocultural factors which impact on differential life expectancy such as socioeconomic status, occupation, lifestyle, environmental conditions, and health care practices. Information on family structure, social networks and problems associated with life transitions and their impact on aging of minorities is also sought.

A number of studies have focused specially on aging in blacks. Among these was a national cross-sectional study of black elderly and three-generation families, including the study of a variety of variables such as health status, attitudes toward work and retirement, and generational differences in aging and in the values these three generations have. Another study focuses on disability and coping among older black women, and still another focuses on the structure of well-being among older blacks and informal social support networks.

Many studies have shown differences in blacks and whites in disease prevalence, in behavioral and social risk factors for illness, in mortality, and in patterns of service utilization; that is, health service utilization. However, there are still many questions about black/white differences in morbidity and mortality in late life. To provide some of the needed data in this area, the institute has awarded a contract for the study of an elderly population of 4,500 persons 65 years of age and older of which at least 50 percent will be black. The purpose of this study is to investigate the influence of social, environmental, behavioral and economic forces on morbidity, mortality and utilization of health services. Data will also be collected on various socioeconomic groups, and there are other studies that have used the same protocol on populations that are basically white. Therefore, we will be able to compare the data from the black population study with the data from the white population.

The National Institute on Aging is also participating in a followup study of the National Health and Nutrition Examination Survey. This is a national probability sample of 14,000 individuals initially assessed in the years 1971 through 1974 when they were between the ages of 25 and 74. The followup study includes representative numbers of minority groups which the initial study did not include, and the data is being analyzed for racial differences in morbidity and mortality and for how racial background influences several variables such as self-perception of health, health care needs, pain and other bodily complaints, and medical care utilization again.

The Institute is planning a series of workshops on minority aging beginning in fiscal year 1986 with the Workshop on Black Aging. Each subsequent workshop will focus on a specific minority group of elderly.

I would like to close my statement with an emphasis on the continuing commitment of the National Institute on Aging to support research on black aging.

Mr. FORD. Thank you very much, Mrs. Bagley.

Mr. FORD. Now the Chair will recognize Mr. Herbert Doggette, the Deputy Commissioner of Operations for the Social Security Administration.

STATEMENT OF HERBERT R. DOGGETTE, JR., DEPUTY COMMISSIONER OF OPERATIONS, SOCIAL SECURITY ADMINISTRATION

Mr. DOGGETTE. Thank you, Mr. Chairman. It is a pleasure to be here today to participate in this hearing. I would like to make a brief comment which I hope will add to the knowledge regarding some of the issues already discussed today, and request that my full statement be entered into the record.

Mr. FORD. Without objection, it will be made a part of the record.

Mr. DOGGETTE. Thank you, sir.

Over the past 50 years the Social Security Program has furnished vital support to millions of aged and disabled black workers and their families and the families of deceased black workers. Without Social Security it is difficult to imagine how many additional American families, both black and nonblack, would have had little or no income to live on when workers were no longer able to provide for them.

You have already heard about SSI. Many of those who receive SSI, or supplemental security income, are black. About 1 million of the 4 million beneficiaries are, in fact, black, and two-thirds of those are women. Blacks are also heavily represented in those receiving SSI who are aged, with at least one in five receiving benefits in that category.

Although Social Security serves virtually everyone and Social Security eligibility rules are, in the main, neutral with respect to race, the fact that there are systemic, demographic, and economic differences between racial groups is reflected in the benefits they receive. For example, shorter life expectancy means that blacks are somewhat underrepresented on the retirement roles. However, the same shorter life expectancy boosts the numbers of surviving family members who receive benefits. While only 8 percent of retired workers on the roles are black, 21 percent of surviving children receiving benefits are black. In addition, black workers have historically received lower average wages, and hence lower Social Security benefits than nonblack workers. As Dr. Flemming has already indicated, the benefit formula is designed somewhat to replace a higher percentage of those low earnings when they do receive benefits, and that has worked effectively over the years since this group generally has the greatest difficulty in setting aside enough funds to take care of their retirement.

The 1979 Advisory Council on Social Security, which included the eminent Dr. Aaron Henry, studied in detail the question of how blacks and other minority groups have fared under the Social Security system. The Council noted the impacts I have just mentioned and, after wrestling with the problem for sometime, decided not to recommend any substantive changes at that time. However, the Council did recommend that any future proposed changes to the program be carefully examined to avoid changes that would have a disproportionate negative impact on minority group members.

In conclusion, Mr. Chairman, we believe that Social Security has played an important role in providing for all Americans earning protection in the event of retirement, disability or death, and, in so doing, has contributed substantially to the economic well-being of the black community.

Thank you very much, Mr. Chairman.

Mr. Ford. Thank you very much.

[The prepared statement of Mr. Doggette follows:]

Prepared Statement of Herbert R. Doggette, Jr., Deputy Commissioner for Operations, Social Security Administration, Department of Health and Human Services

Mr. Chairman, I am pleased to be here to participate in this hearing as part of the Congressional Black Caucus Legislative Weekend. Since the enactment of the Sociat Security Act in 1935, the programs established by that landmark legislation have been instrumental in protecting all elderly Americans from the dire financial hardship that was so widespread among the elderly of the 1930's.

Over the past 50 years the Social Security program has furnished vital support to millions of aged and disabled black workers and their families and to the families of deceased black workers. Social Security has provided a mechanism through which working Americans assure themselves and their families a foundation of earnings protection upon retirement in old age, severe disability, or death. Without Social Security, it is difficult to imagine how many American families, both black and white, would have had little or no income to live on when workers were no longer able to provide for their families.

Since 1974, additional assistance has been provided through the supplemental security income (SSI) program for those low income aged, blind, and diabled persons who are ineligible to receive Social Security benefits or who receive relatively small benefits. SSI is a means-tested program funded from general tax revenues and administered by the Social Security Administration along with the States. This year the basic Federal program guarantees a monthly payment of $325 for eligible individuals and $488 for eligible couples who have no other countable income and who are otherwise eligible under program rules. Aged, blind and disabled individuals who have resources of $1,600 or less than couples who have resources of $2,400 or less may qualify for SSI benefits.

Many of those who receive support from SSI are black. In December 1984, at least 1 million of the 4 million beneficiaries were black; two-thirds of the black beneficiaries were women. Blacks were heavily represented even among aged SSI beneficiaries, at least 22 percent of whom were black.

As of June 30 of this year, about 37 million individuals were receiving monthly Social Security old-age, survivors, and disability insurance benefits—26 million retired workers and their family members, 7 million survivors of deceased workers, and 4 million disabled workers and their family members. The large majority of these beneficiaries—72 percent—were Americans 65 or older. Almost all Americans reaching age 65 today are eligible for Social Security benefits. Ninety-five percent of young children and their surviving parents are eligible for benefits should the family breadwinner die and four out of five workers are protected in the event they should become disabled.

The Social Security program has been restored to a sound financial footing and workers and retirees can continue to rely on Social Security if and when they need it in the decades to come. The enactment of major financing legislation in 1983 was the outcome of a year of careful study by a distinguished bipartisan National Commission on Social Security Reform. The balanced package of changes in Social Security law that they recommended wa quickly enacted into law; it assures adequate program financing for old-age, surviviors, and disability insurance.

Although Social Security serves virtually everyone and all Social Security eiligibility rules are neutral with respect to race, the fact that there are systemic demographic and economic differences between racial groups is reflected in the benefits they receive. For example, while shorter life expectancy means that blacks are somewhat under-represented on the retirement rolls, that same shorter life expectancy boosts the number of surviving family members receiving benefits. While only 8 percent of retired workers on the rolls are black, 21 percent of surviving children receiving benefits are black. And while black workers historically have received lower average wages and, hence, lower Social Security benefits than white workers, the Social Security benefit formula is designed so that benefits replace a higher percentage of the earnings of low earners, on the presumption that they have the most difficulty setting aside funds during their working years for the purpose of supplementing their Social Security benefits.

The 1979 Advisory Council in Social Security examined in some detail the question of how blacks and other minority groups have fared under the Social Security system. Noting the lower average earnings and benefits of nonwhites and their disproportionate share of the disability and survivor beneficiary populations, the Council concluded that "minority group members can now expect to receive from social security as equitable a package of protection as the majority receives." The Council recommended, however, that proposed program changes be carefully examined to avoid changes that would have a disproportionate negative effect on minority group members.

In conclusion, we believe that Social Security has played an important role in providing all Americans with earnings protection in the event of retirement, disability or death and, in so doing, has contributed substantially to the economic well-being of the black community. I would be happy to respond to any questions you or other members of your committee may have.

Mr. **Ford**. At this time, Dr. Joyce Berry, Acting Associate Commissioner of the Office of Program Development of the Administration on Aging.

STATEMENT OF JOYCE BERRY, PH.D., ACTING ASSOCIATE COMMISSIONER, OFFICE OF PROGRAM DEVELOPMENT, ADMINISTRATION ON AGING

Dr. **Berry**. Thank you, Mr. Chairman.

I would like to commend Sam Simmons on his remarks. I think his remarks awakened us to a great extent. And I might just note that he practices what he preaches. He has established the NCBA Estates here in Washington over on 14th Street, NW, and it is not unusual to see him in his office at 9 o'clock at night. And we at the Administration on Aging really appreciate the opportunity to work with the National Caucus and Center for the Black Aged as well as with the National Council on Aging, with Jack Ossofsky.

I would like to just piggyback on some of the remarks that Sam made in terms of what you can do to work with the Federal Government or work in your local community to aid the black elderly. The Administration on Aging administers programs under the Older Americans Act, and we work through a network of State and area agencies on aging. Many of you are aware of this. You are also aware that Dr. Flemming is a former Commissioner of the Administration on Aging and literally a pioneer in forging ahead in terms of affirmative action, and is responsible to a great extent for the establishment of the national minority organizations in aging. And we commend Dr. Flemming for his efforts.

There are four major efforts that I want to bring to your attention that the Administration on Aging is engaged in.

One, the Title III Program of the Older Americans Act which provides the services for older people. With respect to Sam's comments, it is important that you contact your State unit on aging and your area agency on aging to try to encourage increased participation on behalf of the minority elder in the services programs. Services such as home-delivered meals, transportation services, and other types of services that benefit older people. It is important that you know who that director of the State and area agency is.

We also operate a discretionary grants program. Many of you may be familiar with the Title IV Program of the Older Americans Act. Here we fund universities, organizations, other entities to conduct research and explore the problems that affect the minority elder to try to come up with some workable solutions to meeting the needs of the minority elder.

Under that Title IV Program we are trying to assure that we have minority personnel in the network of State and area agencies on aging to serve older people, so we have an internship program which we call the Minority Management Training Program. Here we are trying to make sure that minorities who do graduate from our gerontological training programs get placement in the State and area agencies on aging.

The fourth initiative that I will just briefly mention is the Historically Black Colleges and Universities Initiative. We refer to it as the HBCU Initiative. That initiative was launched by former Commissioner Lennie Marie Tolliver—Dr. Tolliver is the first black Commissioner on Aging—and we have made significant strides with that initiative.

Let me just say a word about the Title III Program in terms of the declining participation of older persons. In 1980, we had a 21-percent participation of older people in the Title III Program. That has dropped to 17 percent in 1984. We are very concerned about it. We have been having biregional meetings with some of the national minority organizations to try to address this concern. There are many theories as to why the participation of the minority elderly is declining. We hope to, in fiscal year 1986, address some of the issues that the States and the area agencies have brought to our attention as possible causes.

With respect to the discretionary grants program, let me just mention that we are working with the National Council of Negro Women in the area of health promotion. We are trying to support them in terms of community-based health promotion programs to encourage the black elderly to adopt certain behaviors that would reduce the risk of poor health.

I mentioned the internship program that we have underway. I will just go back for a second to the Historically Black Colleges and Universities Initiative. We are working with Atlanta University, Hampton Institute, and Meharry Medical College. In Atlanta, we are working to train rural service providers on how to care for the black elderly. At Hampton Institute we are trying to target our efforts on ministers, directors of senior centers, medical personnel, through training and through videotapes, on how to prevent and detect elder abuse. At Meharry we are trying to infuse gerontological content into the curricula of the Schools of Medicine, Dentistry, and Nursing.

So just to summarize, we have four basic efforts ongoing on behalf of the black elderly. The Title III Program under the Older Americans Act. Here we are trying to increase participation of the black elderly in the program of nutrition services, home-delivered meals, and transportation. The Title IV Discretionary Program which provides for the conduct of research, demonstration, education, and training activities. We are working with the Minority Management Internship Program and the HBCU's. And I think some of these efforts represent AOA's concerns.

Certainly it is not enough. Certainly we have a lot more to do. But it certainly indicates that we are concerned about the needs of the minority elderly.

I would like to call your attention to a recent Federal Register announcement that was published on September 4. It was published by the Office of Human Development Services of the Department of Health and Human Services. You may want to take a note that on page 35,932 there is a section, it is section 6.2(d), which deals with increasing minority elderly access to services. Here we are really trying to solicit applications from organizations representing minority groups to help the Administration on Aging target services on the black and other minority elderly persons. We will be funding projects up to $200,000. It is important that applicants work with their State and area agencies on aging and to assist applicants in preparing applications under this announcement. I have additional copies of it here.

We are holding some grantestimonyanship training workshops: five, as a matter of fact. The first will be held at Jackson State University in Mississippi next Monday. We will also be inviting 125 HBCU's and other minority organizations. There are three other sites: one at Morris-Brown College in Atlanta, Meharry Medical College, and the University of the District of Columbia here in town.

So, in conclusion, the Administration on Aging needs your support as we continue to try to find new ways of doing business to ensure improved services to the many black older Americans we serve.

Thank you.

Mr. FORD. Thank you very much, Dr. Berry.

At this time we will hear from our last witness, before we get a response from the audience. Mr. Robert White, who is the national president of the National Alliance of Postal and Federal Employees, was detained because of the weather earlier.

But we are delighted to have you with us, Mr. White, and the Chair will recognize you at this time.

STATEMENT OF ROBERT WHITE, NATIONAL PRESIDENT, NATIONAL ALLIANCE OF POSTAL AND FEDERAL EMPLOYEES

Mr. WHITE. Thank you very much, Mr. Chairman. I certainly want to apologize for being late, but it was unavoidable.

Congressman Ford and fellow panelists, and participants in the Congressional Black Caucus Legislative Weekend Forum on "The Black Elderly in Poverty," I am Robert L. White, national president of the National Alliance of Postal and Federal Employees.

Our union prides itself on the fact that we are responsive to the needs and realities of our retired members and their families. As a matter of fact, our retirees are a strong and effective component of our union. Under my administration a retirees division was instituted in 1974. The head of that division, Mr. Enos Matthews from New Orleans, LA, is an ex officio member of our national executive board.

We understand that we all gain when there is a cross fertilization of ideas between the young and the old. In my opinion, there is nothing greater than the wisdom and experience of the elderly coupled with the creativity and ingenuity of youth. For these and many other reasons, it is a pleasure to be with you today to share some of the NAPFE's insight as to the problems of black elderly in poverty; and more specifically, to provide you with an overview of what we are doing in our own way to help improve the quality of life for the black elderly.

I would like to take this opportunity to commend Congressman Harold Ford for chairing this important forum.

This year 170,000 black Americans will attain the age of 65, based on statistics released last year by the National Center on the Black Aged, and better than half of them will be poor. Even though according to U.S. Census data the number of elderly 65 or over in poverty declined in 1984, the picture is still bleak. The poverty line income for a single elderly person in 1984 was $4,979 and for two persons $6,282. The greatest source of income for the majority of elderly Americans, and nearly the sole source of income for black elderly Americans, is Social Security. Yet, in 1983, the Reagan administration sought to eliminate cost-of-living adjustments, or COLA's as they are popularly known, for Social Security annuitants. COLA's help keep down poverty rates among the elderly. That is why the National Alliance always lobby vigorously against freezes or reductions in the COLA payments to Social Security recipients.

The black elderly's lack of substantial income lead us to another obstacle to a decent and healthy standard of living for far too many of our black elderly. It is a distressing and unconscionable fact that inadequate housing looms as a major problem for our Nation's elderly. The National Alliance of Postal and Federal Employees' commitment to helping meet the pressing national need for affordable and adequate housing for our elderly is evident by the fact that the union presently has 202 housing projects in Chattanooga, TN, New Orleans, LN, and Tampa, FL. Our national elderly housing coordinator Alonzo Adams recently put together applications for two more complexes: one in Atlanta, GA, and the other in Philadelphia, PA. And we were awaiting the decision on those applicants, but now I can tell you that just as late as yesterday we received a decision, and which they have approved our Atlanta project, which is a complex for 98 units at $4,633,000, and that will give us now a total of some 403 units at a total of some $20 million that we have been able to obtain for 202 housing for the elderly.

Obviously the National Alliance has confidence in the section 202 Housing Program. While the housing needs of the elderly cannot be met with Government effort alone, we feel that section 202 is a proven successful program that works. And we further feel that funding for this program should be increased. The 202 Program provides both construction and long-term financing for the housing that is specifically geared to the needs of the elderly and the handicapped. The section 8 Rental Assistance Program renders 202 housing affordable for many who could not afford it otherwise by providing rent supplements for the residents.

In contrast to grant programs, section 202 is a long-term successful program. Significantly, there has been no defaults in the Section 202 Program since its inception. In addition, as a production oriented system, 202 helps stabilize the housing construction industry by creating new housing starts.

With 1,000 people joining the ranks of the elderly daily, we need a variety of housing programs to satisfy a variety of needs. However, the voucher system that the Reagan administration favors in my view fails to satisfy any of those needs. Also, a voucher system would not increase the housing supply. But it may end up subsidizing dilapidated, run-down, unfit housing. Therefore, I would encourage each of you here today to not only support 202 programs, but also to oppose the voucher system and encourage legislators at every level of government, developers, nonprofit organizations, community groups, and voters—especially the elderly, who are a voting force within themselves—to get State and local governments to push creative housing programs such as shared housing and reverse annuity mortgages.

In what other ways can the quality of life for the black elderly be improved? Very quickly let me cite just a few. As a union, the National Alliance is very concerned about the employment opportunities for all. We provide tuition-free continuing education to our members, including our retirees. Many of our retirees as a result have acquired new skills, particularly in computer science. Still others have learned how to start a small business.

The National Alliance is also extremely concerned that the black elderly are often victims of age and race discrimination. This is another important reason why everyone of us should be doing everything in our power to ensure the passage of the Civil Rights Restoration Act of 1985 without amendments. The act would prohibit the Federal Government from subsidizing discrimination on the basis of race, sex, age, or physical handicap.

We must also be vigilant in protecting the health care needs of our black elderly. The National Caucus and Center on the Black Aged released a study 1 year ago that indicated that the elderly's out-of-pocket payment for Medicare protection has increased drastically under the Reagan administration, and this situation must be reversed. While we must consider and push for appropriate cost containment measures, we must also remain adamantly opposed to raising the eligibility age of Medicare from 65 to 67. Since blacks have a shorter lifespan than whites, blacks will lose if the change goes into effect in the year 2000.

In closing, I will only point out that another way to help our black elderly is by supporting the National Caucus and Center on the Black Aged. We must always have a watchdog advocacy group for the black elderly.

I want to thank you very much, Mr. Chairman, for permitting me to present this even though I was late.

Mr. FORD. Thank you very much, Mr. White. I would like to thank all of the witnesses who testified before the committee today.

I would like to first call Dr. Satcher to join me here at the podium. Dr. Satcher, who is the president of Meharry Medical College, also will be hosting the National Conference on Health Care for the Poor on October 7 and 8 in Nashville, TN, at the Meharry Medical College.

We are delighted to have you as part of the braintrust today and as part of this committee hearing, Dr. Satcher.

At this time I would also like to recognize a group that has traveled from my hometown. Maybe we will hear from one of the representatives of that group. The Goodwill Home Community Services, Inc., of Memphis, traveled here with about 16 or 17 of their membership, and we are delighted to have the Goodwill Services with us here at the 15th Annual Conference of the Congressional Black Caucus and for the full Committee on Aging today.

I would like to hear from one of the representatives from the podium. I know that you have heard all of the witnesses testify before the committee today, and perhaps you would like to respond to some of the issues discussed here today.

Ms. CONNELLY. We have long been interested in the black elderly and the poor black elderly as we had the first such center in Memphis and the first day care center in Memphis for the elderly. So your remarks today have long been of concern to us in terms of the clients we serve.

And we want to express our thanks to you, Congressman Ford, for your hospitality and for your support all along the line.

I feel like I am misrepresenting Goodwill Home when I get up here. I would like my staff to stand, if I might ask them.

Mr. FORD. Sure. Let all of them stand. Let me see the people from my hometown. Very good.

[Applause.]

Mr. FORD. Very good.

At this time the Chair would like to recognize Dr. Satcher for some comments and observations.

Dr. SATCHER. Thank you, Congressman Ford. I, also, would like to join in expressing our appreciation to you for not only this hearing, but for the leadership you are providing here for this very important issue.

We at Meharry, as you know, have been concerned with the issue of problems of the elderly in this country as it relates to health services. What we have found, of course, as I think is obvious in this hearing today, is that there are comprehensive needs and it is sometimes very difficult to separate them out and to approach them effectively.

Meharry has, interestingly, at least seven different programs dealing with the elderly. You have heard from Dr. Berry about the curriculum initiative.

We also have a special ward in Hubbard Hospital set aside for the provision of exemplary services to the elderly where we have physicians who are specially trained and interested in the care of the elderly. Also, of course, our residents and students get an opportunity to witness and to participate in exemplary services to the elderly.

We have a long-term management program funded by the Robert Wood Johnson Foundation which is an attempt to deal with the problems of the elderly comprehensively, and not just in a hospital or in a nursing home, but to look at the needs of the elderly as it relates to day care, home care, outpatient services, in-hospital care, skilled nursing services and to try to tie all of these things together into one comprehensive system. I think that is going to make a difference in the long run in terms of our approach.

Meharry is very interested in nutrition, and we are in the process of developing a nutrition center at Meharry that will look at research, education, and service components as it relates to nutrition. We should be announcing very shortly the funding of that nutrition center, which I think in time will make quite a difference in terms of our approach to the care of the elderly as it relates to nutrition.

Our Community Health Center has now for several years provided a day care program for the elderly where we provide the transportation, the nutrition, and the activities on a day-to-day basis for a group of elderly in Nashville.

More recently—in fact, July 1—we opened at Meharry a skilled nursing service, and this has a lot to do with the new approach to reimbursement from Medicare and the fact that many people who after a few days of hospitalization really have nowhere to go immediately. A lot of them don't want to go to a nursing home and are not really able to return to their homes. We now have a service below the acute service where we can maintain the elderly in the hospital for several days at a lower level of service in terms of the amount of care provided. We are very pleased with that because we think it is going to make a difference for a lot of people.

So as you can see, there is a lot of things we are trying to do. The dental school has what they call an Adopt-A-Grandparent Program. The idea being not only to make sure that our faculty and students in dentistry are oriented to some of the unique needs of the elderly in terms of dental care, but also that relationships between the students and others and the people in this program are positive relationships.

I mention all of those things because again I think we struggle to try to provide comprehensively for the needs of the elderly as it relates to our institution and to make sure that our students and residents and others are oriented in that way.

As Mrs. Bagley was speaking about the National Institute on Aging, of course, we have I think two or three grants from the National Institute on Aging.

I also represent the Association of Minority Health Professional Schools as it relates to this issue. That association includes, in addition to Meharry's School of Medicine and Dentistry, of course, the Morehouse School of Medicine, the Drew School of Medicine, three schools of pharmacy—Xavier, Florida A&M, Texas Southern—and then a school of veterinary medicine. But our concern, of course, as we have expressed to the National Institute on Aging, is for more involvement of historically black institutions and black health care workers in research. We are very concerned about that. We are trying to work together to make sure that there is more involvement in terms of positive research in solving the problems of the elderly.

Mr. FORD. Thank you very much, Dr. Satcher.

We are open now for a response from the audience. Any of those who would like to respond to the members of the panel, you are welcome to do so by coming to the podium to my right and to your left.

If you would first identify yourself for the record, please, and then you may proceed.

Dr. BENNETT. Good morning. My name is Dr. Claudette Bennett, and I am a survey statistician at the Bureau of the Census.

I am here to let you know that the Bureau of the Census is very concerned with the aging population. As a result, we do produce aging population data, and I am just introducing to you today a packet that contains information on aging that was produced by the Bureau of the Census in 1983.

Mr. FORD. I want you to know that I have been using parts and portions of that study by the Census Bureau. Perhaps copies of the report could be provided to the participants at this workshop today.

Thank you.

Ms. SMITH. I am Thelma Smith, and I am from New Orleans.

I want to respond to some of the things that Mr. Simmons said. Today is my birthday, and I am 80 years old, Mr. Simmons.

Mr. FORD. Happy birthday to you, then.

[Applause.]

Ms. SMITH. I am also a member of the Senior Voters Caucus of New Orleans. My concern has to do with the need for adequate enforcement of legislative controls and guidelines for programs supposedly established to help the aged. Indepth cost and quality service audits seem to come only in election years. And this is happening to us right now in New Orleans.

In my own State, Charity Hospital Public Health System was once rated one of the best. This is no longer true. As a result, we are seeing the growth of health clinics, nursing homes, daycare centers for disabled and handicapped, and these it seems to me and others of us who are concerned are for profit and are not giving adequate care.

Self-help community groups and volunteers in my city are becoming more sophisticated in their monitoring activities. We do well with nursing homes and with centers that are supposedly handling problems for disabled and handicapped elderly people, but not so well with the health clinic that is supposed to be providing quality health care at less cost. And I think this is where the problem is: we still see that, though these clinics are supposed to be providing access, the cost is exorbitant and the elderly are still denied adequate health care.

In the housing programs, again in our city just last week we discontinued taking any more projects to do rehab housing and rental rehab because of the fraud that is evident in these programs. It is just recently because of the political involvement that is going on between candidates that we are seeing the FBI, HUD, and everybody else is interested in doing indepth auditing of these programs.

I think that we would like our elected officials to know that we are interested, and that we feel that they ought to be accountable to enforce the regulations more often than just at election time.

Thank you.

Mr. FORD. Thank you very much.

Sam, would you like to try to respond?

Mr. SIMMONS. I just want to commend her on the job that she is doing. I certainly encourage you to organize others to carry on a year-round effort in terms of trying to reform the system to be certain that it is fully responsive to the needs of the elderly with particular emphasis on the black elderly. You are to be commended.

Mr. FORD. The Chair will recognize the gentlelady at the podium.

Ms. NELSON. Good evening. My name is America C. Nelson. I am from Washington, DC. Thank you for letting me come.

I have a secret to share with you. My secret is that Wednesday of this week I was 79 years old.

[Applause.]

Ms. NELSON. Please don't tell my elderly boyfriend.

[Laughter.]

Ms. NELSON. Because they are usually looking for younger women. Don't tell him he does not have a younger woman.

[Laughter.]

Ms. NELSON. I am interested in the abuse of the aged. There are so many elderly people now who are poverty-stricken because they have been financially abused. They have been abused by their relatives; sometimes their children, and they do not want to admit this. Sometimes there are widows who have been left property and money sufficient by their husbands, and yet the children or somebody that rooms in the house or a relative will take advantage of this.

Is there some way that we can be encouraged to take care of our assets before it is too late?

The next thing I want to talk about is something that Mr. Simmons said: organizations should help. Well, I am an AKA and I probably say this to those who may be members of another sorority, we do; we help at a nursing home that is very near, in Maryland. But I would like some direct appeal to the civic associations who say they are always looking for something to do and yet they do not take care of the elderly within the community. I happen to be vice president of a civic association.

Again, there are some people who are able to take care of themselves while they are on their feet. They have good income. Some of these people when they become elderly and ill are not able to conform at home, and yet the nursing home charges them $3,000 a month because they own a home. What can be done about that?

And then the next thing that I would like to speak about is we people who are over 70, sometimes we like to continue to work, and we don't always want to go back to teaching school and yet nobody will take us.

Thank you.

Mr. FORD. Thank you very much.

Is there a panelist who would like to respond?

Yes?

Mr. OSSOFSKY. Quite a few questions were raised by the speaker. On the last one in particular, the issue of continued work opportunities is one that the National Council on the Aging has been deeply involved with since its origin some 35 years ago. I think it would be exceedingly helpful, Mr. Chairman, in response to that particular issue if we could once and for all lift the cap on the Age Discrimination in Employment Act so that people of any age have the protection of the law. If they are capable and want to work to be able to do so knowing that the power of the law is behind them.

At the same time as I say that, however, I am cognizant of the fact that the enforcement of ADEA has been weakened in recent years. The largest increase in cases appearing before the EEOC in recent years has been the growth in age cases. The fact of the matter is that there is no strong motivation, no national leadership that calls out for the enforcement of this piece of legislation, particularly around the ADEA matter. And we see that continuing pattern of weakening of affirmative action, whether it is on age or race, being destroyed in the current climate.

Some of the other matters that were raised are complex. The problem of age abuse has been coming to our organization now for a good number of years. The difficulty is that the older people who are the victims are most reluctant to express that victimization; in part, because the victimization often comes from care-givers. Regrettably, it appears that there is a significant amount of that victimization among poor and isolated segments of our older population. We need to do much more research about this issue. It is something just emerging as a visible, knowledgeable issue for the community. We need to study much more about it, find out its origins, look at its social and economic etiology, and begin taking some steps to protect older people. It seems to me just as the issue of child abuse has of late gotten considerable visibility, so the issue of age abuse is first growing in our knowledge and in our understanding. We need to deal with it.

The problem of helping people conserve their resources is another very difficult one. While retirement preparation education might be a tool in that direction that help people know what their resources are and how best to husband them, the fact of the matter is most people don't want to disclose what they have. And when they are able to deal with their own resources, they are well protected. It is at that point of severe disability or disorientation that it becomes an issue, and then it is very late to find some means of protecting it. It is a complex matter, and which we have not yet resolved it.

Mr. Chairman, the last two speakers put me in mind of making one other comment. We have spent most of this morning in a strong expression of concern about the terrible needs of the older poor, and they are real and substantive and need to be dealt with. But the last two speakers underscore for us one other thing about older people in our country, and it is true of older blacks as evidenced by projects the National Council on the Aging has undertaken in this community. And that is, that in spite of economic and health problems these are people who are an asset to our Nation. They are a resource to help us deal with many of the needs of the country.

In the District of Columbia, for example, NCOA has undertaken of late two recent pilot projects with volunteers who are predominantly black serving predominantly black recipients of their services. These older volunteers in one, the Family Friends Project, have volunteered to work in the homes of severely disabled and chronically ill children, helping both the children and the family with their life circumstances.

A second project is a project in which older volunteers are being trained to be literacy aides dealing with the illiteracy that remains prevalent among older people in our country.

These are but two of NCOA's project. They happen to be demonstrations in the District, and I make reference to them to underscore that the volunteers in both instances are older black people of our community. They are helping deal with the needs and the issues in our country, and we need to understand and put into the record our assertion of their value to our country as well as our responsibility to meet the needs of so many.

Thank you, Mr. Chairman.

Mr. FORD. Thank you.

The full Committee on Aging held hearings in July of this year on displaced workers, and I think that there will be some recommendations forthcoming from the full Committee on Aging. It will make certain recommendations to the Congress itself. Hopefully, we will see some action by this full committee in the coming months. If not, at least in the second session of this Congress.

Are there other participants who would like to respond?

Ms. MOTLEY. My name is Barbara Motley, and I am with Goodwill Homes Community Services in Memphis.

The Congressman didn't pay me to say this. This isn't the first time he has been very generous and kind to Goodwill. It is the area where his family comes from, and he has been very supportive of the seniors in southwest Shelby.

But my question is really to you, Dr. Berry. While I enjoyed that and it was very informative, some of that information never reaches Tennessee. Maybe the Postal Service can explain that.

But I am very concerned in terms of paraprofessionals. You know, and even the president from Meharry knows, everybody is not college bound. Some of us in this very room would not like to perform tasks that seniors really need. So in the future I would like to hear more about what is being done for paraprofessionals, especially those already working in organizations. And maybe in the future you can take a look at organizations already working with seniors. As opposed to just putting it in the colleges and universities, maybe you should take a look there.

And since you wanted to hear, I didn't want to leave here without you knowing that.

I want to compliment Mr. Simmons. I think we need more organizations to bridge the gap, you know. And certainly you have inspired us—and this committee, Congressman Ford—to go back and continue to bridge that gap for older Americans.

Thank you.

Mr. **Ford**. Thank you.

Dr. Berry?

Dr. **Berry**. I really appreciate your comments, and it allows me an opportunity to just stress that the Administration on Aging is very concerned about the training of paraprofessionals and continuing education for those people who are involved in providing services to older people. We have recently held a roundtable discussion on education and training, and one of the directors of the State offices on aging said no one wants to do the dirty jobs anymore, and no one wants to focus on providing assistance for those nurse's aides and those homemaker aides.

So in previous announcements, and even in this announcement, we have encouraged applications from community colleges and from other associations that represent paraprofessionals. So that is a very good point. I appreciate that.

Mr. **Ford**. Thank you.

Ms. Nichols?

Ms. **Nichols**. I am Claudette Nichols, Shelby County government, Memphis, TN.

To Congressman Ford, we certainly want to commend you on the exemplary commitment which you have exemplified as it relates to the elderly in our congressional district.

I have many concerns, of course, and want to compliment the various panelists. But one of the issues that is of tremendous concern to us most definitely in Memphis and Shelby County is the care of the homebound elderly. There are many elderly persons who have been discharged from hospitals who cannot afford private nursing care, yet they cannot acquire the services that are rendered by senior citizens services for homemaker services because of the tremendous waiting list. That is a concern that we have.

The other is, Congressman Ford, we are concerned about establishing a national caucus or a black caucus on the elderly in our congressional district, and would certainly be supportive of you in that effort.

Mr. **Ford**. I certainly would say to Mr. Simmons here that the National Caucus on the Black Aged has worked very tirelessly with the braintrust of the Congressional Black Caucus as well as other organizations throughout this country. I certainly would advise and recommend that my congressional district affiliate or join with all of these organizations and institutions that have been so kind to work with us in a fashion that has offered us the information and put together that agenda, not only for the Congressional Black Caucus, but for the Aging Committee as well.

Are there others? And this will be the final response from the audience because the Congressional Black Caucus will ask all participants to join with us at 12:45 in front of the Cannon Building. There will be a march on the Embassy of South Africa today at 1:15. We are going to leave the Cannon Office Building here I think at 1. Everyone will assemble at 12:45. We will participate for a couple of hours in a march on the Embassy of South Africa.

Yes, the Chair will recognize you.

Mr. COTHRAN. My name is Tilman Cothran, a professor of social gerontology and sociology at Western Michigan University in Kalamazoo, MI.

In order that my friend Sam Simmons does not get a big head, I am going to direct my praise to the president of Meharry Medical College.

I listened to your list of services which are being performed there and I am extremely impressed, especially in view of the fact that the American Medical Association patently refuses to declare geriatric medicine an area of specialization and also because of the fact that we do not provide very much training for our medical doctors in the area of geriatric medical procedures. It was only about 2 years ago that we received, or we got established in this country a department of geriatric medicine, and that was done by Robert Butler at Mt. Sinai in New York City. So I want to compliment you on that. Maybe you can get some fire built under the American Medical Association.

My other concern which is I think a very serious one, and that is we are very much concerned about the kind of legislation which comes from Congress dealing with problems of the elderly. But at the same time, once that legislation is produced, it is passed on to some bureaucrats who define the rules, the regulations and the specs which tend to somewhat alter the meaning of much of the legislation to the extent that it becomes somewhat tainted with agism and racism and sexism.

I am especially concerned about this because when we attempt to define poverty we ought to be very clear about how we define it. Are we using the Social Security definition of poverty? Or are we using the Labor Department's definition of poverty? Or what kind of definition do we use?

What we often fail to do is that in the writing of legislation we do not specify enough—and I know legislation needs to be somewhat succinct—so that it cannot be altered by bureaucratic manipulations. The important thing which I think is of very serious concern for us right now, referring to some of the actions which I have come out recently from the Bureau of the Census in giving us the information that the number of poor people is declining in our society. But the problem which I have and the concern that I have is how are they defining poor people? Are they using a fixed income amount or are they bringing in in-kind kinds of considerations? Indeed, if they are using in-kind income in their definition, it is I think grossly unfair to older people when they don't use let us say welfare for the wealthy in deciding the amount of money that various groups in our society will earn or control and making comparisons with poor people. I think that is very important.

Another point, and I won't go on after that. Another important point I think that we ought to be concerned about is that we have had many statements today indicating that older people are living longer and that the black elderly, those of us who arrive at that age, surely live longer. But I think many of the programs should start developing orientations which would be geared toward the growing evidence of four generation families in our society. Most of our concerns has been with basically three generation families.

And finally, I think that one thing which we might be concerned about is providing some assistance to black families who traditionally and historically have operated somewhat from the background of the extended family to the extent that we have had a lot of family care and assistance for the elderly, but no assistance from Federal programs especially for that, or recognition for it. And I think that kind of aid should be included.

Mr. FORD. Thank you very much.

Would either of the panelists like to respond, or have any closing remarks?

Dr. Satcher?

Dr. SATCHER. I would like to take this opportunity to just announce that on October 7 and 8 Meharry Medical College will be celebrating its 110th convocation. It is quite a history. I don't have time to go into it. A lot of you have been involved with Meharry. Certainly Congressman Ford has played a key role in the survival of that institution through some very difficult times. I think the 110th convocation is significant.

We decided to celebrate it by holding a National Conference on Health Care for the Poor. We feel it is time. We feel that there are a lot of forces in this country that are militating against health care for the poor. The emphasis is on cost containment, which is important, but the increased emphasis on competition, for-profit hospitals, and a lot of other things, really, are of concern, so we felt it was time to call national attention to the issue of health care for the poor.

So you are invited to come to Meharry on October 7 and 8. There are programs outside on the table describing that conference.

Thank you.

Mr. FORD. Thank you.

Mr. Ossofsky? No comments.

The Chair would like to thank all of the members who have testified before the committee today. We thank each and every one of the panelists for your contribution that you have made to these hearings today, as well as the participants in the audience.

We would like to close the hearings out now. It is 10 minutes to 1. I will not be able to join the group at 1 o'clock in front of the Cannon Building because the House Ways and Means Committee is in a markup on the tax bill that we have heard so much about in recent months. I must say that we have a strong commitment to protect the elderly in this tax legislation. There are tax matters and tax components of the bill itself that certainly will impact the elderly of this Nation. Hopefully, those strong voices on the Ways and Means Committee will provide protection for the elderly.

Once again, thank all of you for coming out. This will conclude the hearings of the full committee.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

APPENDIXES

APPENDIX 1

POVERTY AMONG AGED BLACKS IN 1984

NUMBER

Poverty declined by 86,000 for Blacks 65 or older during the past year, from 796,000 in 1983 to 710,000 in 1984. However, this is essentially the same level as in 1977 (701,000).

RATE

The poverty rate for aged Blacks dropped from 36.2 percent in 1983 to 31.7 percent in 1984. The current poverty rate (31.7 percent) is essentially the same as in 1978 (33.9 percent) and 1974 (34.3 percent). The bottom line is that the poverty rate for older Blacks has remained essentially unchanged during the past decade.

POVERTY DEFINITION

An individual 65 or older was considered poor in 1984 if his or her annual income was below $4,979 ($6,282 for an aged couple).

COMPARISON WITH AGED WHITES

Older Blacks are three times as likely to be poor as elderly Whites. In 1984, 31.7 percent of all Blacks 65 or older lived in poverty, compared to 10.7 percent among aged Whites. The risk of being poor was nearly four times as great for older Black males as aged White males: 25.9 percent vs. 7.2 percent. Older Blacks were almost three times as likely to be poor as elderly White females: 35.6 percent vs 13.1 percent.

POVERTY AND NEAR POVERTY

Nearly one out of every two (45.6 percent) aged Blacks was either poor or marginally poor in 1984. Persons are considered near poor if their income is above the poverty threshold but not by more than 25 percent.

APPENDIX 2

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) has long recognized that the nearly 3 million older minority persons in the United States are disproportionately represented among the poor and near-poor population and thus has advocated policies that promote the economic, physical and social well-being of older minority individuals. In recent years, AARP has placed increasing emphasis on serving the needs of the low income elderly population in its programmatic and legislative activities and has begun to focus attention on the low income minority elderly. AARP hopes to work closely with other organizations that have as their goal the improvement of the quality of life for low income and all minority elderly both to improve and direct its own efforts and to assist such other organizations whenever possible.

PROGRAM ACTIVITIES

Over one-half million of AARP's members are Black; another 150,000 AARP members are from other minority or ethnic groups. To better meet the needs of these members, AARP launched the Minority Affairs Initiative in December 1984. The goals of the Minority Affairs Initiative are both social and economic: to create a greater awareness of the needs, concerns and quality of life of older minority persons; to review and support existing and future research addressing such issues; to develop models for increasing the social and economic services provided to older minority persons; to work for the elimination of education and employment barriers faced by minority persons of all ages; to initiate and engage in federal, state and local advocacy programs to improve the economic, social and physical status of elderly minority persons; and to work closely with minority communities through AARP volunteers and Field Services as well as other public and private agencies.

Since its inception, the Minority Affairs Initiative has worked hard to develop AARP's internal organizational and membership awarness and ability to achieve the above goals. Its initial programs have focused on health advocacy services (preparing and distributiong public service announcements and other materials on cancer detection aimed at Black males; seminars on the importance of complying with physician treatment programs; and seminars and materials on health care in general); housing services (in conjunction with the National Caucus and Center on Black Aged, a program has been instituted to train older minority persons for new careers in the management of low to moderate income housing in Tampa, Florida); and widowed persons services. Its legislative activities have focused on identifying and prioritizing issues of particular concern to minority elderly on both the federal and state levels and on the development of state and area volunteer structures for purposes of lobbying and engendering grass roots support when necessary. The Minority Affairs Initiative is also planning, in consultation with a minority public relations firm, activities to publicize issues of concern to minority elderly, to develop tax-aid programs and to increase minority involvement in AARP. Existing AARP porgrams and information on consumer education, health issues and energy, safety and crime prevention will be translated or otherwise adopted for use in minority communities and will be supplemented with a family of information on minority elderly including (1) A National Perspective on Minority Elderly brochure, (2) State specific local data, and (3) detailed demographic materials on each of the major minority groups.

The Minority Affairs Initiative in particular needs to work closely with other groups serving the minority elderly and in particular low income minority elderly, and looks forward to being a part of such a coalition. If you have any questions, please call Marie Phillips, Coordinator, Minority Affairs, (202) 728-4808.

LEGISLATIVE ACTIVITIES

Chief among AARP's legislative priorities are (1) the maintenance of affordable and quality health care, (2) adequate, secure and fair public and private retirement income, (3) the provision of necessary social and economic support services to increase the quality of life for the elderly, and (4) an end to discrimination. Many of these priorities reflect AARP's concern over the plight of all the nation's elderly poor. AARP seeks not only to preserve, maintain and, where possible, increase benefits under such programs but also to substantially increase participation by the elderly in receiving such benefits.

Health.—Increases in health care costs pose special problems for the elderly poor/near poor. Out-of-pocket spending expressed as a percent of income is about six times greater for poor/near poor elderly persons than for their middle income counterparts. Moreover, fully one-fourth of the elderly poor/near poor are not protected by Medicaid. AARP has thus worked against additional increases in cost-sharing and premium amounts; the raising of the age of eligibility for Medicare benefits; the means-testing of benefits in Medicare; and other related issues.

Retirement income.—Older persons depend heavily on government programs, particularly Social Security, for income support. Since the oldest and lowest income elderly, mainly minorities and elder women, depend on these programs for 85–95 percent of totals income, any substantial across-the-board program cuts will deepen the poverty of the two million elderly who are just above the poverty line into the poverty category. AARP is therefore dedicated to resisting across the board reductions in income support programs, including cost-of-living protections.

Social and economic support programs.—In addition to traditional social support services that allow older persons to remain vital members of their communities (e.g., senior centers, legal assistance, home delivered and congregate meals, in-home assistance, transportation, education and housing), AARP has fought hard to create and maintain programs to assist low income persons, such as Social Security Income and Food Stamps. These programs are vitally important in halting the deterioration in living conditions of many older Americans, particularly minority elderly. Thus, AARP has supported: (1) an increase in the federal portion of the SSI payment to at least 150 percent of the poverty level, (2) liberalization and automatic inflation adjustment of SSI's partial disregard of unearned income (e.g., Social Security benefits) and increase of the disregard for earned income, (3) elimination of the one-third SSI payment reduction imposed upon persons who live in the household of another and (4) substantial increase in SSI's current assets limitations. With regard to the Food Stamp program (which at present serves only half of the poor older persons who are eligible), AARP has worked to (1) make SSI recipients categorically eligible for food stamps, (2) liberalize the medical expense deduction and include in it the extra cost of special medical diets and (3) have benefits calculated on the basis of the full value of the Thrifty Food Plan and adjusted for inflation. AARP has opposed restoration of the purchase requirement, elimination of the monthly minimum benefit and modification of the economies-of-scale adjustment factors in the belief that these measures would severely affect older and poorer program participants.

In a related vein, AARP has testified in support of continued assistance for low income housing and related programs.

Discrimination.—AARP recognizes that elderly minorities and women face not only age discrimination but race and sex discrimination in employment, receipt of services, education and many other aspects of society. As a member of the Leadership Conference on Civil Rights, AARP has worked hard for the passage of the Civil Rights Restoration Act and will continue to work with the coalition on a variety of employment and other discrimination issues.

Unfortunately, many of the current programs benefitting low income persons are under attack today. The reduction of elimination of such programs will dramatically increase the number of elderly poor, with a commensurate impact on minority elderly. A concerted effort by groups with the mandate and ability to represent the interests of low income elderly and minorities is the only hope for insuring that hard-won benefits and rights are not dissipated. AARP hopes to work with the Congressional Black Caucus, the Select Committee on Aging and all related organizations and agencies on this endeavor. Please call John C. Rother, Director, Legislation, Research & Public Policy Division, (202) 728-4780, or Sana F. Shtasel, Director, Federal Affairs, (202) 728-4730.

APPENDIX 3

National Policy Recommendations by the National Caucus and Center on Black Aged, Inc., 15th Annual Conference, 1985

INCOME

Inadequate income in retirement is the number one problem confronting older Blacks today. In 1983, 796,000 aged Blacks—more than one out of every three Blacks 65 years or older—were poor. Individuals 65 or older were considered poor in 1983 if their annual income was below $4,775 ($6,023 for an aged couple), according to the U.S. Census Bureau.

Another 273,000 elderly Blacks were marginally poor. Their income was barely above the poverty threshold but not more than 25 percent. The bottom line is that almost 1.1 million (1,069,000) aged Blacks were either poor or marginally poor.

Older Blacks are more than three times as likely to be poor as elderly Whites. In 1983, 36.3 percent of all Blacks 65 or older lived in poverty, compared to 12.0 percent for aged Whites.

Poverty is especially widespread among elderly Black women. More than two out of every five (41.7 percent) aged Black women lived in poverty in 1983, and more than half (54.5 percent) were either poor or marginally poor. One of the poorest groups in our society is the aged Black woman who lives alone or with nonrelatives. About five out of eight (63.4 percent) were poor in 1983, and more than three out of four (76.3 percent) were poor or near poor.

Poverty is just one dimension of the retirement income crisis that affects aged Blacks and threatens to engulf so many more. Large numbers of elderly Blacks may not be officially poor or near poor, but they are still living on tight budgets. For example, 40.7 percent of all aged Black single males and 70.2 percent of elderly Black single women had income below $5,000 in 1983. Moreover, the overwhelming proportion of individual Blacks 65 or older had annual income below $10,000 in 1983—76.1 percent of all aged Black males and 93.1 percent for elderly Black females.

Social Security and other income (primarily Supplemental Security Income) constitute nearly three out of every four dollars (73 percent) received by aged Blacks. Social Security accounts for 62 percent, and other income represents 11 percent. Therefore, it is crucial that these programs be built upon solid foundations.

Recommendations

The federal Supplemental Security Income (SSI) standards should be raised to levels above the poverty lines so that aged, blind, and disabled persons can have sufficient income to meet their day-to-day living expenses.

The SSI benefit standard should not be reduced by one-third when aged, blind or disabled recipients live in the household of another for a full month and receive maintenance and support because this provision discourages children from helping their parents or grandparents.

Congress should resist all attempts to cap or freeze the Social Security cost-of-living adjustment because this proposal could plunge 1 million older Americans into poverty by the end of this decade. Moreover, Social Security is financially sound now, according to the most recent report of the Social Security board of trustees.

A special elderly Consumer Price Index should be established to measure more accurately the impact of inflation upon Social Security and SSI beneficiaries.

The provision in the 1983 Social Security Amendments to boost the eligibility age for full benefits from 65 to 67 should be repealed because this measure discriminates against Blacks and other minorities, since they have a shorter life expectancy than Whites.

The Social Security Administration should conduct effective outreach projects to assure that more elderly Blacks and other low-income persons receive the SSI benefits to which they are legitimately entitled.

EMPLOYMENT

Older Blacks have been exposed to double jeopardy in the job market because of their age and race. Their problems are further intensified because they were raised at a time when widespread discrimination existed. They typically attended inferior schools, notwithstanding the so-called "separate but equal" doctrine. Many were forced to drop out of school to help at home or for other reasons. To a very large degree, they were shortchanged in being given necessary tools to compete in a society that has become more urbanized and service oriented. These earlier handicaps take their toll in the employment market now in various ways.

Older Blacks typically have an unemployment rate that is two to three times the level for aged Whites. In 1983, for example, Blacks 65 or older were nearly three times as likely to be unemployed as older Whites. The elderly Black unemployment rate was 9.3 percent, compared to 3.2 percent for Whites 65 or older.

Aged Blacks also receive the shorter end of the stick if they are able to work. Their median earnings represent 76.6 percent of that for older Whites. In 1983, the median usual weekly earnings for a full-time wage earner amounted to $199.91 for Blacks 65 or older, compared to $261.06 for aged Whites. Older Blacks have a substantially reduced earnings capacity which reflects lower educational attainment, outmoded work skills, discrimination (despite enactment of laws to prohibit job bias because of race, age, and sex), and other factors.

A recent Department of Labor study by the Bureau of Labor Statistics shows that many older workers who lost their jobs in recent years have not been able to return to the work force. In fact, the likelihood of becoming re-employed is inversely related to age. About 70 percent of displaced workers 20 to 24 years old who lost their jobs between January 1979 and January 1984 were employed again in January 1984, compared to only 41 percent for those 55 to 64 years old and just 21 percent for those 65 years or older.

These facts underscore the need for a comprehensive and effective policy to maximize job opportunities for older workers.

Recommendations

Funding for the Title V Senior Community Service Employment Program (SCSEP) should be increased to provide more job opportunities for low-income persons 55 or older.

The Senior Environmental Employment program should receive a line item appropriation to provide meaningful employment for older Americans, while improving our environment at the same time.

Service Delivery Areas should make greater use of Title V National sponsors to enroll more economically disadvantaged persons 55 or older in Job Training Partnership Act programs.

The Equal Employment Opportunity Commission should enforce the Age Discrimination in Employment Act vigorously and effectively. One member of the Commission should be knowledgeable concerning age-related job bias.

Mandatory retirement should be abolished.

The Social Security earnings limitation should be liberalized to permit older persons to keep more of their earnings when they work.

Congress should repeal the two-stage reduction in the Title V administrative cap from 15 percent to 12 percent by July 1, 1987, because this provision will (1) create an urban bias for the program, (2) force sponsors to consolidate projects, (3) cause displacements for some Title V enrollees, and (4) operate unfairly for national minority sponsors who do not have the economies of scale that the larger sponsors have.

Congress should emphasize again in the law that older persons with the poorest employment prospects are the top priority group to be employed by the SCSEP.

HEALTH

By any barometer one would choose to use, older Blacks have poorer health than aged Whites. More than one-half (55.1 percent) of all Blacks 65 or older consider their health to be poor or just fair, compared to one out of three (33.1 percent) for elderly Whites. Restricted activity days for aged Blacks is nearly 41 percent higher than for older Whites: 43.4 days per year compared to 30.8 days. Older Blacks are confined to a bed, on the average, approximately 58 percent more than aged Whites: 22.3 days versus 14.1 days per year.

Perhaps the most readily apparent effect is the significantly shorter life expectancy for Blacks than for Whites. Life expectancy for White men was 6.6 years longer than for Black males in 1982: 71.5 years compared to 64.9 years. White women can expect to live, on the average, 5.3 years longer than Black females: 78.8 years versus 73.5 years.

Aged Blacks and other older minorities have also been victimized by our two-tier health system, which provides quality care for the affluent and middle class but "welfare medicine" for low-income persons. The emphasis is clearly on institutional care. Precious little attention is paid to preventive measures.

Medicare and Medicaid represent landmark legislative achievements for aged Blacks and other older Americans. But, the protection from these valuable programs has been whittled away in recent years. The Medicare Part A Hospital Insurance deductible has nearly doubled during the past four years, from $204 in 1981 to $400 today. Similarly, the Part B Supplementary Medical Insurance deductible has risen by 25 percent, from $60 in 1981 to $75 currently. And, the Part B premium has jumped by 50 percent, from $123.60 in 1981 to $186 in 1985.

Medicaid has also been cut sharply in recent years. Low-income aged Blacks have been among the major casualties of these reductions. They have taken many forms—cutbacks in nursing home care, new out-of-pocket payments, and the elimination or reduction of prior benefits.

Recommendations

Congress should resist further cutbacks in Medicare protection as a means to strengthen Medicare's financing. The emphasis should be on controlling hospital, doctor, and other health care provider costs.

Congress should reject proposals to increase the eligibility age from 65 to 67 for Medicare.

Alternatives to institutional care should be encouraged. The current bias in our health care system toward institutionalization should be overcome. In-home health care services should be promoted.

New initiatives should be developed to promote preventive measures to ward off illness and to encourage wellness among the elderly.

Congress should not enact further Medicaid cutbacks. Cost containment should be the primary goal rather than cuts in benefits.

Funding for the National Institutes of Health should be targeted to combat diseases affecting the elderly and minorities, including Alzheimer's disease, cancer, heart, stroke, hypertension, and others.

As a long-term goal, our Nation should enact a universal and comprehensive national health insurance program with built-in cost controls. Until this can be achieved, Medicare should be improved by capping out-of-pocket payments for hospitals and medical services.

A new National Institute of Arthritis and Musculoskeletal and Skin Diseases should be established, as proposed in the Health Research Extension Act (H.R. 2409).

LONG-TERM CARE

Long-term care refers to a wide range of services, including diagnostic, therapeutic, rehabilitation, and maintenance services for people with chronic impairments. These services can be delivered in institutional (such as hospitals, skilled nursing homes, or intermediate care facilities) and non-institutional (such as the home) settings.

Older Blacks have been underserved by long-term care institutions. Several factors account for their lower participation rate, nursing homes and other long-term care facilities:

Many Blacks simply cannot afford the high cost of skilled nursing care.

Discrimination, whether covert or overt, still exists, even though this practice is prohibited.

Some facilities, which serve primarily Blacks, are unable to meet fire, safety, and other code requirements because of limited resources.

Nursing homes are often viewed with suspicion and deep concern by older Blacks because of news accounts about dreadful conditions that exist in some facilities.

In many cases, a nursing home is the only alternative for older Americans with chronic conditions. However, large numbers of elderly persons with health problems can live independently in their homes with appropriate care. Unfortunately, a sizeable proportion of aged individuals are unnecessarily or prematurely institutionalized at a much higher public cost. In fact, our health care system seems to have a built-in bias toward institutionalization. Estimates range from 15 percent to 40 percent concerning the number of nursing home and hospital patients who are inappropriately institutionalized.

Recommendations

A more balanced approach should be developed to meet the health needs of older Americans. Emphasis should be placed on community-based services. Policies should recognize that the family is the largest service provider for aged Blacks.

State agencies on aging should strengthen their nursing home ombudsman programs to assure that the rights of nursing home patients are adequately protected.

A fundamental objective of our long-term care policies should be increased accessibility for older Blacks. Strict enforcement of civil rights legislation is absolutely essential.

States should enact a nursing home bill of rights to assure that patients are treated humanely and receive quality care.

The Geriatric Research, Education, and Training Act (S. 1100) should include special provisions to promote training of Black professionals in the health professions.

Concrete steps should be taken to improve the administration of drugs in nursing homes, including (1) the right of patients to choose their own pharmacy should be secure; (2) the law prohibiting kickbacks should be vigorously enforced; and (3) the patient's name, the medication price, the name of the drug, the size of the dose, and the total drugs supplied should be printed on each prescription label.

HOUSING

Housing is the number one expenditure for the elderly. Many older Americans spend at least one-third of their income for housing. A significant percentage spend substantially more.

Housing is perhaps the most visible sign of deprivation among aged Blacks. For example, elderly Blacks are 3-½ times as likely as older Whites to be without plumbing for their exclusive use. About three out of seven (43.5 percent) houses occupied by aged Blacks lack central heating.

Today, thousands of older Blacks live in ramshackle, deteriorating or unfit housing. Many find themselves in an impossible housing situation. Their homes may be old, crumbling and deteriorating. Yet, they lack the financial resources or the skills to repair their dwellings to make them more habitable.

This problem is further intensified by rising property taxes and other related costs. The net impact is that older Blacks are frequently trapped within their present unsuitable living arrangements because appropriate and affordable alternative housing—such as an apartment, shared housing or other arrangements—are usually not available or at a price within their reach.

Most elderly families are homeowners. However, homeownership is much more prevalent among aged Whites than older Blacks. Nearly three out of four (72.1 percent) White households with an aged head own their homes, compared to three out of five (57.8 percent) for elderly blacks.

Recommendations

Congress should reject attempts to eliminate funding for new housing contruction, housing rehabilitation, and other housing assistance.

H.R. 1, the 1985 Housing Act, should be enacted into law expeditiously. This measure would extend most housing programs for one year. Overall, H.R. 1 would finance an estimated 105,000 public housing and section 8 units.

Section 202 housing for the elderly and handicapped should be continued with sufficient lending authority to finance at least 12,000 units.

The congreate housing services program should be continued with at least a $10-million authorization. This program should eventually become a cornerstone in our strategy to assist "at risk" individuals in remaining in their own homes. The congregate housing services program should be more than a demonstration program to test out innovative concepts to promote independent living.

The Title V Senior Community Service Employment Program should focus increased attention on home repairs to assist low-income older persons to live in a suitable environment, especially elderly widows who may lack the resources to pay for repairs or the knowledge to perform the necessary work.

The cap on rents for tenants in federally-assisted housing should be reduced from 30 percent to 25 percent of adjusted income.

Congress should enact legislation to (1) prohibit the Department of Housing and Urban Development from requiring a competitive bidding process for selecting contractors for section 202 projects; (2) bar HUD from using older FHA guidelines for establishing per unit cost limitations which would be significantly lower than the current 202 limitations; (3) prevent HUD from requiring more than 25 percent of section 202 units be efficiencies; (4) cap section 202 loans at 9.25 percent; and (5) prevent HUD from requiring a minimum capital investment exceeding $10,000 for section 202 projects.

CRIME

Older Blacks are much more likely to be victimized by crime than aged Whites. Many elderly Blacks live under a form of "house arrest" because they are afraid to venture out in to their crime infested neighborhoods.

Yet, their limited income may make it impossible to move to a safer environment. Moreover, the "uprooting" may have adverse psychological effects for those persons who have lived in their neighborhoods for several years.

Today older Blacks are reluctant to report crimes. They often fear retaliation from the perpetrators of the crime. Large numbers simply lack confidence in the criminal justice system. They have seen from experience that criminals normally do not get caught. When they are apprehended, they still may not be convicted. Even if they are convicted, they may be on the streets again to perform their criminal acts. Freedom from fear is clearly one of the highest priority needs for older Blacks.

Recommendations

Our nation's efforts to combat crime should focus on prevention. Many crime prevention techniques are already available, including neighborhood watches, security checks, the installation of security devices, escort services, and others. They have been tested, and the results have generally been positive. The key is to educate the public about effective crime prevention techniques.

Community crime prevention services should not operate in isolation. To be fully effective, they must be coordinated with a wide range of other services to assure a more comprehensive approach to reduce crime as well as assist victims. These include victim assistance, services at community mental health centers, and other crisis services.

The involvement of the local community is an indispensable element in combating crime. Police departments should educate older Americans and others about their fundamental responsibility to control crime and provide instruction concerning appropriate steps to reduce the likelihood of being victimized.

Strong and effective handgun control laws should be enacted to make it more difficult for criminals to obtain weapons to commit crimes.

The Civil Rights Commission should investigate "hate" groups—such as the Ku Klux Klan and the American Nazi Party—which encourage violent attacks against elderly Blacks and other aged minorities.

SUPPORTIVE AND NUTRITION SERVICES

Income alone cannot solve all the problems confronting elderly Blacks and other low-income older Americans. An effective services strategy is also necessary because many of the aged's basic problems transcend economic considerations.

For example, transportation may pose a dilemma regardless of income, especially for aged persons who do not drive. Older Americans who have transportation at their disposal find it much easier to cope with challenges related to advancing age. But "without wheels," the daily living experience can be a form of imprisonment. Routine tasks—such as shopping, visiting friends or going to the doctor—can be a formidable task for an individual without a car or suitable public transportation. Unfortunately, today, older Americans frequently live under a form of "house arrest" because public transportation is often unavailable, inaccessible, or too expensive.

The Older Americans Act has helped to deliver a wide range of services for the aged, including congregate meals, home-delivered meals, transportation, outreach, information and referral, legal and others. However, a clear need exists to serve aged minorities more effectively and equitably. This point was made emphatically in the recent Civil Rights Commission report.

Recommendations

The Administration on Aging should enforce fully and effectively the provisions in the 1984 Older Americans Act Amendments to improve services for aged minorities.

Services programs for low-income older Americans should be exempt from budget cuts.

Congress should approve a three-year extension of the Legal Services Corporation, as proposed in H.R. 2468.

The 1985 Food Stamp and Commodity Distribution Improvement Act (H.R. 2422) should be enacted into law. A number of provisions in H.R. 2422 would benefit low-income older Americans, including a liberalization of the medical expense deduction and an increase in the liquid asset limitation. These measures will make it easier for the elderly to qualify for food stamps and receive higher benefits.

Congress should enact H.R. 700—the 1985 Civil Rights Restoration Act—which overturns the *Grove City College* decision. H.R. 700 would restore four major civil rights laws—the 1985 Age Discrimination Act, Title VI of the 1964 Civil Rights Act, section 504 of the 1973 Rehabilitation Act (prohibits discrimination against the handicapped), and Title IX of the 1972 Education Amendments (forbids sex discrimination)—to the broad scope of coverage that marked their administration prior to the *Grove City College* case.

EDUCATION, RESEARCH, AND TRAINING

Research, training, and education are essential if the field of aging is to remain dynamic. Unfortunately, these activities have had elements of "step-childism."

Funding, for example, for the Title IV Research, Training, and Demonstration program was cut by 59 percent within a two-year period, from $54.3 million in fiscal year 1980 to $22.2 million in 1982. Fortunately, this disturbing trend was reversed last year when the Congress approved a 13-percent increase, boosting funding from 22.2 million to $25 million. This represents, though, only a modest beginning to restore funding for Older Americans Act research, training, and demonstration activities.

Title IV has proved to be a sound investment for our nation. It has helped to provide competently trained personnel to deliver services to older Americans. It has been a catalyst for innovative demonstration activities. And, it has yielded important research to assist policymakers, practitioners in the field of aging, and others.

Research is vital for a nation to keep abreast in a changing world and to develop the body of knowledge to make intelligent decisions. It is also crucial to enable our society to understand and to deal with diseases associated with the aging process.

Recommendations

Funding for the Older Americans Act Title IV program should be at least at $25 million for fiscal year 1986.

The Administration on Aging should comply with Senate Appropriations Committee report language to use part of the $2.8 million funding increase for fiscal year 1985 to develop new initiatives to serve aged minorities more effectively.

The National Institute on Aging (NIA) should undertake additional research concerning the shorter life expectancy for minorities. The studies should include recommendations to increase life expectancy for minorities.

NIA should take additional steps to improve the capability of researchers from historical Black colleges to compete successfully for grants from the National Institutes of Health.

The Geriatric Research, Education, and Training Act should be enacted into law. However, S. 1100 should be amended to promote the training of minorities for careers in aging-related occupations.

APPENDIX 4

A PROFILE OF ELDERLY BLACK AMERICANS PREPARED BY THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

DEMOGRAPHICS

Numbers.—More than 2.2 million Blacks were 65 or older in 1983. Nearly all older Blacks lived outside institutions (2,123,000). In 1980, there were 84,175 Blacks 65 or older in institutions.

Percentage of aged.—Elderly Blacks account for more than 8 percent of all persons 65 or older in the United States.

Sex.—About three out of every five (60.2 percent) older Blacks are women, and two out of five (39.8 percent) are men.

Comparison with whites.—The ratio of older men to aged women is slightly higher for Whites—40.8 percent of all White older Americans are males (39.8 percent for Blacks), and 59.2 percent are females (60.2 percent for Blacks).

Projections.—Almost 3 million (2,975,000) Blacks will be 65 or older by the year 2000. The Black elderly population will more than triple within the next 50 years, reaching 7.3. million by 2030.

Source: Bureau of the Census, Department of Commerce.

GEOGRAPHICAL DISTRIBUTION

More than 100,000 older blacks.—Nine states (New York, Texas, Georgia, California, North Carolina, Illinois, Louisiana, Alabama, and Florida) had more than 100,000 Blacks 65 or older in 1980.

Top ten.—Nearly three out of five (56.3 percent) older Blacks lived in ten states. This includes the nine states with more than 100,000 aged Blacks plus Pennsylvania (96,000 elderly Blacks).

Top twenty.—In 1980, 90 percent of all Blacks 65 or older lived in twenty states (the top ten listed above plus Mississippi, Virginia, Ohio, Michigan, South Carolina, Tennessee, New Jersey, Maryland, Missouri, and Arkansas).

POPULATION OF BLACKS 65 OR OLDER IN THE TOP 20 STATES IN 1980

State	Thousands	State	Thousands
New York	164	Mississippi	94
Texas	143	Virginia	87
Georgia	119	Ohio	84
California	115	Michigan	83
North Carolina	114	South Carolina	77
Illinois	109	Tennessee	71
Louisiana	108	New Jersey	58
Alabama	106	Maryland	58
Florida	101	Missouri	46
Pennsylvania	96	Arkansas	46

Source: Bureau of the Census, Department of Commerce.

POPULATION OF BLACKS 65 OR OLDER BY STATES IN 1980

State	Thousands	State	Thousands
Alabama	106	Montana	0.1
Alaska	.2	Nebraska	3
Arizona	5	Nevada	2

POPULATION OF BLACKS 65 OR OLDER BY STATES IN 1980—Continued

State	Thousands	State	Thousands
Arkansas	46	New Hampshire	.1
California	115	New Jersey	58
Colorado	5	New Mexico	1
Connecticut	11	New York	164
Delaware	7	North Carolina	114
District of Columbia	43	North Dakota	([1])
Florida	101	Ohio	84
Georgia	119	Oklahoma	20
Hawaii	.2	Oregon	2
Idaho	.1	Pennsylvania	96
Illinois	109	Rhode Island	2
Indiana	30	South Carolina	77
Iowa	3	South Dakota	.1
Kansas	10	Tennessee	71
Kentucky	26	Texas	143
Louisiana	108	Utah	.4
Maine	.1	Vermont	.1
Maryland	58	Virginia	87
Massachusetts	13	Washington	5
Michigan	83	West Virginia	10
Minnesota	3	Wisconsin	7
Mississippi	94	Wyoming	.2
Missouri	46		

[1] Less than 50 Blacks 65 or older.

Source: Bureau of the Census, Department of Commerce.

INCOME

Sources.—Social Security (47 percent) and other income (10 percent—primarily Supplemental Security Income) accounted for 57 percent of the total income of Blacks 65 or older in 1981. Among elderly Blacks living alone, these three sources represented almost three out of four dollars (73 percent): Social Security accounted for 62 percent and other income constituted 11 percent.

Under $5,000.—Nearly 41 percent (40.7 percent) of aged Black single males and 70.2 percent of elderly Black single women had incomes below $5,000 in 1983. The poverty threshold was $4,775 for a single aged person in 1983.

Under $10,000.—The overwhelming proportion of individual Blacks 65 or older had annual incomes below $10,000 in 1983—76.1 percent of all aged Black males and 93.1 percent for elderly Black females.

Median incomes.—Black males 65 or older had a median income of $5,807 in 1983. The median income for elderly Black women ($3,995) was $780 below the official poverty index for a single aged person.

Comparison with whites.—Median income for aged Black males was only 57 percent of that for elderly White males ($10,179). The median income for older Black females was 67% of the level for elderly White females ($5,813). Aged Black single males (40.7 percent) were nearly three times as likely to have annual incomes below $5,000 than older White single men (15.5 percent).

Source: Bureau of the Census, Department of Commerce "Aging America: Trends and Projections," U.S. Senate Committee on Aging and the American Association of Retired Persons.

POVERTY

Poverty level.—Individuals 65 or older were considered poor in 1983 if their income was below $4,775 ($6,023 for an aged couple), according to the U.S. Census Bureau.

Numbers.—In 1983, 796,000 aged Blacks—more than one out of every three Blacks 65 or older—were poor. Another 273,000 were marginally poor. Their income was barely above the poverty threshold but not more than 25 percent. The bottom line is that almost 1.1 million (1,069,000) elderly Blacks were either poor or near poor.

Percentage poor and near poor.—Aged Blacks had a 36.3 percent poverty rate in 1983. Nearly one out of every two Blacks (48.8 percent) 65 or older was either poor or marginally poor.

Comparison with whites.—Older Blacks are more than three times as likely to be poor as elderly Whites. In 1983, 36.3 percent of all Blacks 65 or older lived in pverty, compared to 12.0 percent for aged Whites.

Women.—More than two out of every five (41.7 percent) elderly Black women lived in poverty in 1983, and more than half (54.5 percent) were either poor or marginally poor.

Women living alone.—One of the poorest groups in our society is the aged Black woman who lives alone or with nonrelatives. About five out of eight (63.4 percent) were poor in 1983, and more than three out of four (76.3 percent) were poor or near poor.

Source: Bureau of the Census, Department of Commerce.

HEALTH

Perceived health status.—More than one-half (55.1 percent) of all Blacks 65 or older consider their health to be poor or just fair. Approximately one out of four (24.5 percent) aged Blacks view their health as excellent or very good. The remaining 20.5 percent consider their health to be good.

Comparison with whites.—Aged Whites are more likely to have a positive view of their health status—35.2 percent consider their health to be very good or excellent compared to only 24.5 percent for elderly Blacks. About one out of three (33.1 percent) Whites 65 or older views his or her health as fair or poor.

Restricted Activity days—Aged blacks and elderly whites.—Restricted activity days for aged Blacks is nearly 41 percent higher than for elderly Whites (43.4 days vs. 30.8 days).

Bed days—aged blacks and elderly whites.—Older Blacks are confined to a bed, on the average, approximately 58 percent more than aged Whites (22.3 days vs. 14.1 days per year).

Source: National Center for Health Statistics, Department of Health and Human Services.

LIFE EXPECTANCY

Life expectancy.—Life expectancy at birth in 1982 was 64.9 years for Black males and 73.5 years for Black females. At age 45, Black men can expect to live 25.9 years, and Black females live on the average 30.0 more years. Life expectancy at age 65 is 13.3 years for Black males and 14.5 years for Black females.

Comparison with whites.—Life expectancy for White men was 6.6 years longer than for Black males in 1982 (71.5 years vs. 64.9 years). White women (78.8 years) can expect to live on the average 5.3 years longer than Black females (73.5 years). The differential narrows at age 65. Life expectancy at that age is 14.5 years for White men, compared to 13.3 years for Black males. At age 65, it is 18.9 years for White women and 17.2 years for Black females.

Source: National Center for Health Statistics, Department of Health and Human Services.

HOUSING AND QUALITY OF LIFE

Ownership and rentals—aged blacks and elderly whites.—In 1980, 57.8 percent of all households with an aged Black head were owner occupied. And, 42.2 percent of elderly Black households were renters. Aged Whites are much more likely to own their homes than elderly Blacks. Nearly three out of four (72.1 percent) White households with an aged head own their homes, compared to three out of five (57.8 percent) for elderly Blacks.

Plumbing—aged blacks and elderly whites.—Nearly one out of twelve (8.4 percent) elderly Black households lived in housing lacking complete plumbing for their exclusive use. Older Black households are 3½ times as likely to be without plumbing for their exclusive use than elderly Whites (8.4 percent vs. 2.4 percent).

Heating—aged blacks and elderly whites.—About three out of seven (43.5 percent) houses occupied by aged Blacks lacked central heating. Older Blacks are almost 2½ times as likely to live in housing without central heating than aged Whites (43.5 percent vs. 18.4 percent).

Kitchens—aged blacks and elderly whites.—One out of every 14 (7.3 percent) aged Black households lived in housing lacking a complete kitchen facility. Elderly Black households are four times as likely to be in housing without a complete kitchen facility than older Whites (7.3 percent vs. 1.8 percent).

Phone—aged blacks and elderly whites.—One out of eight (12.3 percent) elderly Black households did not have a telephone. Aged Blacks are three times as likely as older Whites to have no phone (12.3 percent vs 4.1 percent).

Air conditioning.—The vast majority of housing occupied by elderly Blacks (67.0 percent) did not have air conditioning in 1980. Aged Blacks are 1½ times as likely as older Whites to live in a dwelling without air conditioning (67.0 percent vs. 44.9 percent).

Car—aged blacks and elderly whites.—One out of two (49.1 percent) older Black households did not have a car available. Older Black households are almost twice as likely to be without an automobile than elderly Whites (49.1 percent vs. 26.7 percent).

Source: Bureau of the Census, Department of Commerce.

LIVING ARRANGEMENTS

Households.—About 24 out of 25 (96.0 percent) aged Blacks lived in households in 1983. Only 4.2 percent resided in group quarters, such as a nursing home, boarding home or other group arrangement.

Homes for the aged.—Only 3.4 percent of all Blacks 65 or older lived in homes for the aged (essentially nursing homes but this terminology also includes other long-term care facilities).

Effect of age.—The proportion of Blacks in homes for the aged increases markedly with age. Black females 85 or older are more than 12 times as likely to be in a home for the aged as those 65 to 69 years old (13.5 percent vs. 1.1 percent).

Comparison with whites.—Elderly Whites are more than 1.5 times as likely to reside in homes for the aged as older Blacks (5.0 percent vs. 3.2 percent). At more advanced ages, Whites are almost twice as likely to reside in these facilities. For example, 15.8 percent of White males 85 or older are in homes for the aged, compared to 8.4 percent for Black men in this same age group. Among women 85 years or older, 26.4 percent of White females are in homes for the aged, in contrast to 13.5 percent for Black women.

Source: Bureau of the Census, Department of Commerce.

EMPLOYMENT

Unemployment rate—aged blacks and older whites.—Blacks 65 or older were nearly three times as likely to be unemployed in 1983 than aged Whites. The elderly Black unemployment rate was 9.3 percent, compared to 3.2 percent for Whites 65 or older.

Earnings.—The median usual weekly earnings for a full-time wage earner amounted to $199.91 for Blacks 65 or older in 1983, compared to $261.06 for older Whites. This represents just 76.6 percent of the median usual earnings for older Whites.

Source: Department of Labor.

EDUCATION

Median attainment.—In 1984, the median educational attainment for older Blacks ranged from 6.8 years for persons 75 years or older to 8.7 years for those 65 to 69 years old.

Men and women.—Aged Black women have a higher level of educational attainment than elderly Black men, although the level of schooling for both groups is low. The median educational attainment ranges from 7.3 years for Black females 75 or older (6.0 years for Black males 75 or older) to 8.9 years for Black women 65 to 69 years old, 8.4 years for Black men 65 to 69 years old).

High school.—Only about one out of five (approximately 22 percent) elderly Blacks has completed high school.

Comparison with whites.—Older Blacks have only two years of schooling for every three years for elderly Whites. The median level of educational attainment for Whites (both sexes) is 12.3 years for those 65–69 years old (8.7 years for Blacks in the same age group), 12.0 years for those 70–74 (7.9 years for Blacks), and 10.1 years for those 75-plus (6.8 years for Blacks). Aged Whites are about 2½ times more likely to have completed high school than elderly Blacks (approximately 50 percent vs. 22 percent).

Source: Bureau of the Census, Department of Commerce.

MARITAL STATUS

Married.—Older Black males (69.0 percent) were more than twice as likely to be married in 1983 as elderly Black females (32.2 percent). Less than one-third of all Black women 65 years or older were married.

Widowed.—Nearly three out of every five (59.2 percent) Black females 65 or older were widowed. Almost three out of four aged Black women (73.7 percent) 75 years or older were widowed. One out of four (23.9 percent) older Black males was widowed.

Widows and widowers.—There are nearly four times as many Black widows as Black widowers. In 1983, 757,000 Black women 65 or older were widowed, compared to 202,000 aged Black males.

Comparison with whites.—Aged White females are mor likely to be married than older Black females (40.8 percent vs. 32.2 percent) and less likely to be widowed (49.5 percent vs. 59.2 percent).

Source: Bureau of the Census, Department of Commerce.